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In The

Supreme Court of the United States

GREENVILLE WOMEN'S CLINIC;
WILLIAM LYNN, M.D., ON BEHALF OF THEMSELVES
AND THEIR PATIENTS SEEKING ABORTIONS,

Petitioners,

v.

COMMISSIONER, SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL
CONTROL; GOVERNOR OF SOUTH CAROLINA;
CHARLES MOLONY CONDON, IN HIS OFFICIAL
CAPACITY AS ATTORNEY GENERAL OF THE
STATE OF SOUTH CAROLINA,

Respondents.

**On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Fourth Circuit**

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether a state may review, copy and retain abortion patients' complete medical records without protecting those records from public disclosure, and without demonstrating a countervailing public interest for the privacy intrusion.

2. Whether a state may require abortion providers to form professional affiliations with clergy persons, including at least one Protestant.

3. Whether a state may make abortion facility licensing contingent upon the cooperation of area hospitals that are free to deny their cooperation because of opposition to abortion.

4. Whether a state may require abortion providers to comply with regulatory requirements that have no fixed meaning and will be defined by inspectors on a case by case basis.

LIST OF PARTIES

The Petitioners are Greenville Women's Clinic and William Lynn, M.D., on behalf of themselves and their patients seeking abortions.[1]

The Respondents are Commissioner, South Carolina Department of Health and Environmental Control; Governor of South Carolina; and Charles M. Condon, in his official capacity as Attorney General of the State of South Carolina.

RULE 29.6 CORPORATE DISCLOSURE STATEMENT

Neither of the Petitioners is a publicly-held corporation or a corporation owned by parent corporations.

[1] Charleston Women's Medical Clinic, Inc. ("CWMC") was a plaintiff in this lawsuit but is not a petitioner at this stage in the proceedings. Subsequent to trial, the assets of CWMC were bought by another company, and CWMC no longer exists.

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Petitioners respectfully pray that a writ of certiorari issue to review the judgment and decision of the United States Court of Appeals for the Fourth Circuit entered on September 19, 2002, which upheld the constitutionality of South Carolina Code Annotated Regulation 61-12 (2002).

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit is reported at *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control*, -- F.3d --, 2002 WL 31928629 (4th Cir. Sep. 19, 2002). A copy of that opinion is reproduced in the appendix at A1-50.[2] The Fourth Circuit's November 8, 2002, Order granting Plaintiffs' Petition for Rehearing *En Banc* is reproduced in the appendix at A61-63. The Fourth Circuit's November 15, 2002, order revoking the November 8, 2002, order and denying Plaintiffs' Petition for Rehearing *En Banc* is reproduced in the appendix at A64-66. The opinion of the United States District Court for the District of South Carolina is unreported. A copy of the district court's slip opinion is reproduced in the appendix at A51-60.

This case was previously before the Fourth Circuit on an earlier appeal. The Fourth Circuit's decision on that appeal is reported at 222 F.3d 157 (4th Cir. 2000). That opinion reversed a decision of the district court reported at 66 F. Supp. 2d 691 (D.S.C. 1999). This Court's denial of certiorari in the earlier appeal is reported at 531 U.S. 1191 (2001).

JURISDICTION

The opinion of the United States Court of Appeals for the Fourth Circuit was entered on September 19, 2002. A petition for rehearing *en banc* was denied on November 15, 2002, by a five to four vote in favor of granting rehearing, with two judges abstaining. This Court has jurisdiction under 28 U.S.C. §1254(1).

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[2] The appendix to this Petition is cited as "A__".

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

U.S. CONST. amend. I, which provides in pertinent part that "Congress shall make no law respecting an establishment of religion ... ."

U.S. CONST. amend. XIV, which provides in pertinent part: "No State shall ... deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

S.C. CODE ANN. § 44-41-75 (2002), which provides:

> (A) A facility in which any second trimester or five or more first trimester abortions are performed in a month must be licensed by the department to operate as an abortion clinic and must comply with the provisions of Article 3.
>
> (B) The department shall promulgate regulations concerning sanitation, housekeeping, maintenance, staff qualifications, emergency equipment and procedures to provide emergency care, medical records and reports, laboratory, procedure and recovery rooms, physical plant, quality assurance, infection control, and information on and access to patient follow-up care necessary to carry out the purposes of this section.

S.C. CODE ANN. REGS. 61-12 (2002), which is reproduced in the appendix at A67-125.

STATEMENT OF THE CASE

I. Petitioners.

Petitioner Greenville Women's Clinic ("GWC") is a medical practice in Greenville, South Carolina, that is owned and operated by Drs. Buffkin and Campbell, who provide first-trimester abortions and other gynecological services. Petitioner Dr. Lynn is a physician who, during much of the

pendency of this lawsuit, provided first-trimester abortions and other gynecological care in his medical practices in Beaufort and Greenville, South Carolina. Following the trial in this matter, Dr. Lynn closed his Beaufort office because it was no longer economically sustainable. A161. Subsequently, during the course of this appeal, Dr. Lynn also closed his Greenville practice for economic reasons. In both cases, the cost of complying with the Regulation was one of the economic factors leading to the closure. Since closing his Greenville office, Dr. Lynn has been providing abortions to women from South Carolina and elsewhere in another physician's medical practice in a neighboring state.

II. The Regulation.

Prior to 1995, South Carolina only required licensing of physicians' offices and clinics in which second-trimester abortions were performed. In 1995, the South Carolina legislature began requiring licensing of any "facility in which any second trimester or five or more first trimester abortions are performed in a month," and directed the South Carolina Department of Health and Environmental Control ("DHEC") to promulgate regulations for such facilities. S.C. CODE ANN. § 44-41-75 (2002). DHEC subsequently promulgated S.C. CODE ANN. REGS. 61-12 (2002) ("R. 61-12" or "the Regulation"), thirty-seven pages of requirements with which a medical practice must comply in order to obtain a license allowing it to be able to perform five or more first-trimester abortions (or even one second-trimester abortion) per month. Violation of the Regulation, including the failure of a covered facility to obtain a license, is a misdemeanor. S.C. CODE ANN. § 44-7-340 (2002). In addition, a covered facility found to be in violation of the Regulation is subject to suspension or revocation of its license and/or the assessment of a monetary penalty by the Department. R. 61-12 § 103. The Regulation designates each provision as a Class I, II or III violation, and establishes a schedule of penalties, which

range up to $5,000 per day for some violations. *Id.* The regulatory provisions at issue here fall into three categories.

A. Disclosure of Private Medical Information.

Section 102(F)(2) of the Regulation gives DHEC inspectors "access to all ... records" in an abortion facility, including patients' individual medical records, and gives the inspectors "authority to make photocopies of those documents." R. 61-12 § 102(F)(2) ("disclosure provision"). An abortion patient's medical records contain a great deal of personal information, such as the fact that she is undergoing an abortion, her history of past pregnancies and abortions, and her history of past psychological and physical conditions and treatment. Patients' medical records also contain extensive identifying information, such as the patient's "name, address, telephone number, social security number, date of birth, father's and mother's names when patient is a minor, husband's name, and name, address and telephone number of person to be notified in the event of an emergency." R. 61-12 § 401(A)(1). Inspections of an abortion facility and its records may be triggered by a single, anonymous, telephonic complaint to DHEC. A144-145.

The Regulation itself makes no provision for redacting patient names and other identifying characteristics from medical records, nor does it mandate that DHEC officials maintain the records' confidentiality. Moreover, while state law prohibits disclosure of patients' identities in some contexts, it explicitly permits public disclosure of abortion patients' complete medical records in proceedings "involving the licensure or certification of need of the [abortion] facility or licensing proceedings against an employee of the facility." S.C. CODE ANN. § 44-7-310 (2002).

B. Clergy Requirement.

Section 307 of the Regulation requires, *inter alia*, that "[a]rrangements shall be made for consultation or referral services in the specialties of ... clergy ... to be available as

needed." R. 61-12 § 307 ("the clergy provision"). According to DHEC, the clergy provision requires that the physician "make prior arrangements" with these clergy consultants "ahead of time to ensure that [they] [a]re immediately available should the physician wish to refer a patient to them." A143. Thus, as George Moore, the principal drafter of the Regulation and the Director of Outpatient and Home Care in DHEC's Division of Licensing testified, the abortion provider must make advance arrangements for particular clergy to "be on call" to handle patient referrals. A143. Also, according to DHEC, the facility must make those arrangements with clergy of two or three different denominations, at least one of which must be Protestant. A143. DHEC inspectors will then evaluate whether a facility's choice of clergy and clergy arrangements satisfy the Regulation. A143.

C. Delegation of Licensing Authority to Third Parties.

Under §§ 101(J), 205(C)(2), 305(A), and 309(B) of the Regulation, abortion providers must either: (a) have admitting privileges at a local hospital that has successfully sought state certification as an abortion provider;[3] or (b) have a documented transfer arrangement with a local hospital certified as an abortion provider and a written consulting agreement with a physician who has admitting privileges at such a hospital. The Regulation imposes no standards on hospitals' decisions whether to seek certification as abortion providers, nor does it impose standards governing hospitals' admitting privilege determinations.

D. Vague Requirements.

The Regulation subjects abortion providers to penalties not only for failing to comply with the requirements enumerated in the Regulation, but also for acting in any way that is

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[3] In order to become certified as suitable for the performance of abortions, a hospital must itself seek certification from DHEC. S.C. CODE ANN. REGS. 61-16 § 104.

"against the best practices as interpreted by the Department." R. 61-12 § 103(C).[4] These requisite "best practices" are defined by DHEC inspectors on a "case by case basis." A141-142. DHEC inspectors are authorized to cite abortion providers for a Class III violation if they are not in compliance with a best practice defined by a DHEC inspector. A141-142. Physicians may be subject to monetary penalties for "best practices" violations after the first day on which DHEC requires compliance with any enunciated "best practice." R. 61-12 § 103(C).

III. Statement of Facts.

Confidentiality is vital to women seeking abortions because they may face harassment and violence from their partners or others for having decided to undergo an abortion. *See* A133; A128; A130-A132; A162. Consequently, the disclosure provision may force patients to delay their abortions until they can go to a state where their confidentiality will be maintained, to go to an unlicensed provider, or to attempt to self-abort. Each of these alternatives poses serious risks to patient health. A162; A160-161; *see also* A133; A128. Rather, requiring patients to give their husbands' names for their medical records may cause women to give their physicians false information about their identities, thus impairing their physicians' ability to protect their health. A160. The disclosure provision also forces abortion providers to choose between violating the Regulation and violating their duty of confidentiality to their patients. A139; A156-159; A133-134; A129-130; A132. Notably, anti-abortion demonstrators have in the past obtained and publicly distributed potentially-

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[4] Section 103(C) states that "Class III violations are those that are not classified as Class I or II in these regulations or those that are against the best practices as interpreted by the Department." R. 61-12 § 103(C). The first day of a Class III violation does not call for a monetary penalty; after that time, Class III violators are subject to monetary penalties ranging from $100 to $5,000. R. 61-12 § 103(F).

identifying, confidential information that a South Carolina abortion provider submitted to DHEC. A134-138; A147-152 (indicating patient's town, county and zip code of residence, marital status, age, race, ethnicity, and education level).

IV. Procedural Background

In 1996, the Plaintiff-Petitioner abortion providers ("Plaintiffs") filed this suit for declaratory and injunctive relief on behalf of themselves and their abortion patients, claiming that the Regulation: (1) denies Plaintiffs and their patients equal protection of the laws; (2) deprives Plaintiffs' patients of their right to privacy; (3) violates patients' rights to informational privacy by breaching the confidentiality of their medical information; (4) violates the Establishment Clause; (5) violates Plaintiffs' right to due process by delegating to third parties unbridled veto power over facility licensing; and (6) is void for vagueness. After a six-day bench trial, the district court granted judgment to Plaintiffs on their equal protection and privacy claims and permanently enjoined enforcement of the Regulation. *Greenville Women's Clinic v. Bryant,* 66 F. Supp. 2d 691 (D.S.C. 1999). The district court declined to reach Plaintiffs' remaining claims.

Defendants-Respondents ("Defendants" or "the State") appealed the judgment to the Fourth Circuit, which reversed, upholding the Regulation in its entirety. *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 175 (4th Cir. 2000). This Court subsequently denied Plaintiffs' petition for certiorari without comment. *Greenville Women's Clinic v. Bryant*, 531 U.S. 1191 (2001). On remand, the district court granted Plaintiffs judgment on their informational privacy claim, but dismissed Plaintiffs' vagueness, unlawful delegation and Establishment Clause claims. *Greenville Women's Clinic v. Bryant*, No. 6:96-1898 slip op. (D.S.C. Aug. 31, 2001). The parties filed cross-appeals to the Fourth Circuit, which, over the dissent of Judge King, reversed the district court's grant of judgment to plaintiffs on their informational privacy claim

and affirmed the district court's dismissal of plaintiffs' three other claims. *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control*, -- F.3d --, 2002 WL 31928629 (4th Cir. Sep. 19, 2002).

Plaintiffs filed a Petition for Rehearing *En Banc*, which the Fourth Circuit granted on November 8, 2002. A61-63. However, one week later, the Fourth Circuit issued an order vacating its prior order as "improvidently granted." A64-66. The November 15, 2002 order stated that five judges voted in favor of granting the petition, four voted against and two abstained, and that because Plaintiffs had failed to secure a majority of all of the active judges on the court, the petition was denied. A64-66.

REASONS FOR GRANTING THE WRIT

I. The Decision Below Contributes to a Conflict Among the Circuits as to the Constitutional Protection for Individuals' Informational Privacy.

In *Whalen v. Roe*, this Court held that it did not "decide any question which might be presented ... by a system [for disclosure of confidential information] that did not contain comparable security provisions." 429 U.S. 589, 605-06 (1977). This case presents the question left open by this Court in *Whalen*.

As explained earlier, *see supra* at 4, the disclosure provision authorizes DHEC to review and copy abortion patients' unredacted medical records without protecting the confidentiality of the patients' identities or medical information. The district court invalidated this provision because defendants failed to justify their intrusion into patients' private medical records. A58-59. The majority below ("majority") reversed, applying rational basis review to the provision, and upholding it despite recognizing that state law authorizes public disclosure of abortion patients' medical records in state licensing proceedings. A23-25.

The majority's ruling contributes to a growing conflict among the circuits as to the existence of a constitutional right to informational privacy and the appropriate analysis for claims made under that right. The decision is also unprecedented in upholding a state's intrusion into private information where the government is actually authorized to publicly disclose that information. Certiorari should be granted to resolve these conflicts.[5] *See* SUP. CT. R. 10(a), (c).

A. South Carolina Law Undisputedly Authorizes Disclosure of Abortion Patients' Medical Records in Licensing Proceedings.

It is undisputed that South Carolina law authorizes DHEC to disclose abortion patients' complete medical records, including patient-identifying information, in proceedings "involving the licensure or certification of need of the [abortion] facility or licensing proceedings against an employee of the facility." S.C. CODE ANN. § 44-7-310 (2002). While the State and majority below have cited to state laws offering some measure of protection against disclosure in other contexts,[6] they concede that state law

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[5] At the very least, the questions of whether a state may obtain individuals' medical records without protecting them from public disclosure and whether an intrusion into informational privacy must be justified by countervailing state interests are important questions of federal constitutional law that should be resolved by this Court. *See* SUP. CT. R. 10(c). *Cf. Reproductive Servs., Inc. v. Walker*, 439 U.S. 1307, 1308 (Brennan, Circuit Justice 1978) (stating that "[t]he question sought to be raised by applicant — whether the names of abortion patients can be obtained by discovery for use in a civil suit against a person or clinic performing abortions where, as here, the parties have not agreed to a protective order to ensure the privacy of those patients — is a serious one. If this question were in fact presented by this case, I am of the view that four Members of this Court would vote to grant certiorari to hear it.").

[6] The majority and the State first rely on Section 44-7-310 of the South Carolina Code, which prohibits public disclosure of patient identifying information but includes the exception described above, which explicitly permits disclosure of such information in licensing proceedings. The

authorizes DHEC to disclose patients' medical records in public licensing proceedings. *See* S.C. CODE ANN. § 1-23-600(A) (2002) (providing that administrative hearings are generally open to the public); A24 (acknowledging that there is an exception to confidentiality protections in "a proceeding involving licensure"). Indeed, the State has admitted that its justification for authorizing inspectors to copy patients' medical records is to allow DHEC to preserve those records as possible evidence to be submitted in administrative hearings. A145.[7]

Having acknowledged that state law fails to prohibit DHEC from disclosing patients' medical records in licensing

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majority and the State also cite Section 44-7-315 of the South Carolina Code, which actually *requires* DHEC to disclose publicly, upon request, any information it has received from an abortion facility. The only exception is that DHEC may not disclose "the identity of individuals present in the facility." S.C. CODE ANN. § 44-7-315. This exception, however, applies only to public information requests, not to licensing proceedings where abortion patients' identities may be disclosed. Moreover, even where the exception applies, it fails to protect patient confidentiality because it does not indicate whether it protects the identities of individuals regularly present in the facility (such as staff), individuals present at the time of the DHEC visit, or something else. A33-34 (King, J., dissenting). It also fails to indicate whether it prohibits disclosure of *potentially*-identifying information such as a patient's address, race, age, and marital status. As previously noted, anti-abortion activists have already obtained and distributed such potentially-identifying patient information submitted to DHEC by abortion facilities. *See supra* at 6-7. Third, the majority and the State refer to various laws that require abortion providers and their staff to maintain patient confidentiality, but impose no duty on DHEC or its inspectors. *See* S.C. CODE ANN. § 44-41-60; R. 61-12 §§ 204(F)(3), 209, 402. Because any abortion patient's medical records may ultimately be disclosed in a licensing proceeding, these protection in other contexts offer women little in the way of confidentiality protection.

[7] The only other basis that the State has asserted for the disclosure provision is a desire to spare inspectors the administrative burden of staying at abortion facilities long enough to review the records there. A145.

proceedings, the majority asserted that the courts would prevent such disclosure in accordance with constitutional requirements. A25. The majority based this assertion on a provision of state law that governs enforcement proceedings under the South Carolina Woman's Right to Know Act. S.C. CODE ANN. § 44-41-360 (2002). In such enforcement actions, the court must determine whether to protect an abortion patient's identity from public disclosure. S.C. CODE ANN. § 44-41-360. The Woman's Right to Know Act has no application to this case, nor to the administrative licensing hearings that are at issue here. *See* S.C. Code. Ann. § 44-41-310 *et seq.*[8] Thus, the issue in this case is not whether public disclosure of information obtained under the Regulation is possible: that disclosure is explicitly authorized by statute. The question is whether the State's gathering of highly confidential information in these circumstances is constitutional.

B. There is a Split Among the Circuits as to How to Approach Informational Privacy Claims.

In *Whalen v. Roe*, this Court declared that an individual's right to privacy includes an interest in "avoiding disclosure of personal matters." 429 U.S. 589 at 599. In analyzing the constitutionality of a statute requiring physicians and pharmacists to report prescriptions of certain controlled drugs, this Court balanced the state interest served and the means the state employed against the threat posed to individual privacy. *Id.* at 594-98. This Court upheld the challenged statute, determining that the degree of intrusion imposed on privacy was justified because: (1) the reporting requirement addressed a "vital" state interest and "could reasonably be expected" to serve that interest, *id.* at 597-598; (2) public disclosure of the confidential information was expressly pro-

[8] This Court has previously granted certiorari to correct the improper construction of state law by a court of appeals where, as here, the court's construction flatly contradicted the law's explicit provisions. *See Leavitt v. Jane L.*, 518 U.S. 137, 138 (1996).

hibited, *id.* at 594; and (3) New York employed extensive safeguards, including criminal penalties, to prevent unauthorized disclosure of the confidential information, *id.* at 594-95. *See also Nixon v. Adm'r of Gen. Servs.*, 433 U.S. 425, 458-59 (1977) (applying a comparable balancing test to an informational privacy claim). With respect to this last factor, *Whalen* emphasized that "[t]he right to collect and use [personal information] for public purposes is typically accompanied by a concomitant statutory or regulatory duty to avoid unwarranted disclosures." *Whalen*, 429 U.S. at 605.[9]

Since *Whalen*, the courts of appeals have reached conflicting conclusions about whether a constitutional right to informational privacy exists at all. The majority of circuit courts — namely, the First, Second, Third, Fifth, Seventh, Ninth, Tenth, and Eleventh Circuits — have interpreted *Whalen* as establishing a constitutional right against disclosure of personal information. *See Planned Parenthood v. Lawall*, 307 F.3d 783, 790 (9th Cir. 2002); *Denius v. Dunlap*, 209 F.3d 944, 956-57 (7th Cir. 2000); *James v. City of Douglas*, 941 F.2d 1539, 1543-44 (11th Cir. 1991); *Daury v. Smith*, 842 F.2d 9, 13 (1st Cir. 1988); *Barry v. City of New York*, 712 F.2d 1554, 1559 (2d Cir. 1983); *Denver Policemen's Protective Ass'n v. Lichtenstein*, 660 F.2d 432, 435-36 (10th Cir. 1981); *United States v. Westinghouse Elec. Co.*, 638 F.2d 570, 578 (3d Cir. 1980); *Plante v. Gonzalez*, 575 F.2d 1119, 1132-36 (5th Cir. 1978). The Fourth Circuit held similarly prior to announcing the decision below. *See Walls v. City of Petersberg*, 895 F.2d 188, 192 (4th Cir. 1990).

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[9] The *Whalen* Court dismissed the alleged "chilling" effects of the statute there on the grounds that the State could permissibly prohibit entirely the use of controlled drugs. 429 U.S. at 602-03. In this case, the impact of the disclosure provision cannot be so dismissed, as the states cannot prohibit abortion. *See, e.g., Stenberg v. Carhart*, 530 U.S. 914, 921 (2000) (reaffirming that the right to abortion is a constitutionally protected element of a woman's fundamental liberty interest).

In analyzing informational privacy claims, these circuits, like the *Whalen* Court, have applied a balancing test to determine whether the public need for the particular disclosure outweighs the individual's privacy interest.[10] *See, e.g.*, *Lawall*, 307 F.3d at 790; *Denius*, 209 F.3d at 956-57; *James*, 941 F.2d at 1544; *Barry*, 712 F.2d at 1559-61; *Lichtenstein*, 660 F.2d at 435; *Westinghouse*, 638 F.2d at 578; *Fadjo v. Coon*, 633 F.2d 1172, 1176 (5th Cir. 1981). Prior to announcing the decision below, the Fourth Circuit also applied this balancing approach. *See Walls*, 895 F.2d at 192, 194.

These courts have reached conflicting conclusions, however, about the type of state interest that is needed to justify a privacy intrusion. Some circuits require a compelling state interest, *see, e.g., Paul P. v. Verniero*, 170 F.3d 396, 402 (3d Cir. 1999); *Lichtenstein*, 660 F.2d at 435-36, while others accept a legitimate interest if it sufficiently justifies the intrusion at issue, *see, e.g. Denius*, 209 F.3d at 956-57; *Fadjo*, 633 F.2d at 1176. Prior to issuing the decision below, the Fourth Circuit upheld privacy intrusions only upon a showing of "a compelling governmental interest in disclosure." *Walls,* 895 F.2d at 192.

The circuits recognizing a right to informational privacy also require protections against public disclosure before upholding a privacy intrusion.

See, e.g., Nixon, 433 U.S. at 458-59; *Am. Fed'n of Gov't Employees v. United States Dep't of Hous. & Urban Dev.*, 118 F.3d 786, 793 (D.C. Cir. 1997); *Barry*, 712 F.2d at 1561-63; *Lichtenstein*, 660 F.2d at 436; *Westinghouse*, 638 F.2d at

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[10] The Third Circuit, for example, considered the following factors in its balancing: "the type of record requested, the information it does or might contain, the potential for harm in any subsequent nonconsensual disclosure, the injury from disclosure to the relationship in which the record was generated, the adequacy of safeguards to prevent unauthorized disclosure, the degree of need for access, and whether there is an express statutory mandate, articulated public policy, or other recognizable public interest militating toward access." *Westinghouse*, 638 F.2d at 578.

579-80; *see also, e.g., Denius*, 209 F.3d at 956-57 (rejecting claim of qualified immunity where release of medical information was authorized); *Bloch v. Ribar*, 156 F.3d 673, 684-86 (6th Cir. 1998) (holding that plaintiff stated informational privacy claim where the state disclosed the personal information it obtained); *James*, 941 F.2d at 1544 (same); *Fadjo*, 633 F.2d at 1175 (same).

These decisions stand in sharp contrast to the decisions of the Sixth, Eighth and District of Columbia Circuits, which have all questioned the existence of any constitutional right to informational privacy. As the Sixth Circuit has explained:

> Absent a clear indication from the Supreme Court, we will not construe isolated statements in *Whalen* and *Nixon* more broadly than their context allows to recognize a general constitutional right to have disclosure of private information measured against the need for disclosure. –

J.P. v. DeSanti, 653 F.2d 1080, 1090 (6th Cir. 1981). Accordingly, the Sixth Circuit will only apply a balancing test to an informational privacy claim if the alleged privacy right implicates a fundamental liberty interest, *Kallstrom v. City of Columbus*, 136 F.3d 1055, 1061 (6th Cir. 1998), or if the state has actually disseminated private information to the public, *Bloch*, 156 F.3d at 684-86. The Eighth Circuit, for its part, has held that the disclosure of personal information only violates an individual's constitutional rights if it is "either a shocking degradation or an egregious humiliation of her to further some specific state interest, or a flagrant breech of a pledge of confidentiality which was instrumental in obtaining the personal information." *Alexander v. Peffer*, 993 F.2d 1348, 1350 (8th Cir. 1993). The D.C. Circuit has applied a balancing test to informational privacy claims, but has also directly questioned the existence of any such constitutional right:

> We begin our analysis by expressing our grave doubts as to the existence of a constitutional right of privacy in the nondisclosure of personal information. Were we the first to confront the issue we would conclude with little difficulty that such a right does not exist, but we do not, of course, write on a blank slate. The Supreme Court has addressed the issue in recurring dicta without, we believe, resolving it.

Am. Fed. of Gov't Employees, 118 F.3d at 791-94. The decision below significantly adds to this fray by moving the Fourth Circuit from the position held by the majority of circuits to the minority position of requiring nothing more than a rational basis to justify significant privacy intrusions.

C. The Circuit Courts' Varying Approaches to Informational Privacy Claims Lead to Very Different Results.

The majority applied rational basis review to the disclosure provision and upheld it on the grounds that it was "meaningful to the overall health and safety purposes of Regulation 61-12," and that personal information was adequately protected from disclosure, despite DHEC's authority to disclose that information in licensing proceedings.[11] A23-

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[11] Oddly, the majority's analysis of the challenged disclosure provision focuses almost entirely on the Regulation's record keeping and reporting requirements, which Plaintiffs did not challenge. Similarly, the majority refers to the National Abortion Federation's ("NAF") standards governing physicians' maintenance of patient records and reporting of statistical information despite the fact that Plaintiffs challenge no such provisions. A19. The majority fails to mention the NAF standard governing disclosure of patient records, which states in part that "[e]very woman has the right to expect her privacy will be respected and confidentiality of her records protected ... if a member of the facility receives a subpoena for a woman's records, action must be taken to prohibit release of the records without the woman's consent." A157. Thus, the majority appears to

25. The majority never addressed the intensely personal nature of the information available to DHEC, nor did it discuss in what way the disclosure provision could conceivably serve a legitimate state interest. Nor did the majority inquire whether any such state interest is sufficiently important to justify the degree of privacy intrusion imposed by the provision, or whether there would be an adequate fit between the scope of information subject to disclosure under the Regulation and the alleged interest to be served. Finally, the majority failed to ensure that safeguards exist to prevent public disclosure of the confidential information. Had the majority applied the balancing test utilized by the First, Second, Third, Fifth, Seventh, Ninth, Tenth, and Eleventh Circuits, and thus considered each of these factors, the majority would have been compelled to strike down the disclosure provision.

First, the degree of intrusion on the patients' privacy interests here is substantial. *See Ferguson v. City of Charleston*, 532 U.S. 67, 78 (2001) (policy of drug testing urine of pregnant women was substantial invasion of privacy where, *inter alia*, the results were not protected from unauthorized dissemination to third parties). The unredacted medical records of Plaintiffs' patients — which reveal such matters as the patients' identities, abortion decisions and past medical histories — are undoubtedly highly personal and within the patients' reasonable expectation of privacy. *See Ferguson*, 532 U.S. at 78 (holding that "[t]he reasonable expectation of privacy enjoyed by the typical patient undergoing diagnostic tests in a hospital is that the results of those tests will not be shared with nonmedical personnel without her consent"); *Westinghouse*, 638 F.2d at 577 (holding that "medical records, which may contain intimate facts of a personal nature, are well within the ambit of materials

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have upheld the disclosure provision on the basis of its analysis of other, non-material provisions of the Regulation.

entitled to privacy protection"). This Court has long recognized that a woman has a right to confidentiality with respect to her abortion decision. As the *Thornburgh* Court explained, "[t]he decision to terminate a pregnancy is an intensely private one that must be protected in a way that assures anonymity." *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists,* 476 U.S. 747, 766 (1986); *see also Bellotti v. Baird*, 443 U.S. 622, 655 (1979) (Stevens, J., concurring) ("It is inherent in the right to make the abortion decision that the right may be exercised without public scrutiny....").

Second, these weighty privacy concerns cannot be justified by any legitimate state interest. As the dissenting judge below explained:

> The only justification offered by the State is that such information is needed in order to investigate complaints against abortion clinics. However, the State has failed to demonstrate a need to contact patients in such situations. In fact, complaints involving compliance with issues such as structural building requirements and staff qualifications could be fully investigated by the State without contacting the female patients. And on issues involving patient care, the affected patients would most likely consent to the disclosure of their identity.

A31-32 (King, J., dissenting). Indeed, the Regulation's compromise of patient confidentiality directly threatens the State's purported interest in the health of abortion patients. *See supra* at 6. Although this Court has recognized the states' interest in requiring abortion providers to keep *basic statistical information* about their patients in a manner that "properly respect[s] a patient's confidentiality and privacy," *Planned Parenthood v. Casey*, 505 U.S. 833, 900-01 (1992) (quoting *Planned Parenthood v. Danforth*, 428 U.S. 52, 80

(1976)), it has never recognized a state interest in unfettered access to patients' unredacted medical records, much less such access without protection of patient confidentiality.

Third, the means employed by the State — giving DHEC inspectors free access to the unredacted medical records of all patients at regulated facilities without protecting the confidentiality of those records — is grossly disproportionate to any possible legitimate interest of the State. As the dissenting judge below recognized:

> In limited situations, the State might have a valid need to obtain a patient's identity in order to investigate anonymous complaints or to seek corroborating evidence. However, South Carolina's interest in obtaining patients' identifying information in those limited situations does not support the disclosure requirement in the Regulation, which gives the State access to information identifying *every* patient of *every* abortion clinic in the State.

A32 (King, J., dissenting) (emphasis in original). If DHEC wishes to review the complete medical record of a patient who has filed a complaint, it can simply request the patient's consent to such disclosure. If DHEC cannot obtain that consent and it wishes to access the medical record of a particular patient for a good reason, DHEC can seek a warrant to do so. Thus, just as in *Thornburgh*, "[t]he scope of the information required ... belie[s] any assertions by the [state] that it is advancing any legitimate interests." *Thornburgh*, 476 U.S. at 766.[12]

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[12] The court below wholly failed to consider whether the disclosure of such confidential information *to the State* denies women's right to informational privacy, regardless of any *public* disclosure. In this respect, the opinion below conflicts with *Whalen* and the decisions of numerous circuit courts, all of which explicitly recognize that disclosure *to the state* may itself implicate privacy interests. *Whalen*, 429 U.S. at 602; *see also,*

Finally, the State has failed to provide adequate safeguards against public disclosure of patients' private medical information because it permits disclosure of that information in licensing proceedings.[13] Those proceedings are open to the press and any other interested persons, including those who participate in activism against abortion patients and providers. *See* S.C. CODE ANN. § 1-23-600 (2002). Thus, due to the disclosure provision, "women seeking abortions in South Carolina have a great deal more to fear than stigma. The protests designed to harass and intimidate women entering abortion clinics, and the violence inflicted on abortion providers, provide women with ample reason to fear for their physical safety." A36 (King, J. dissenting); *see also supra* at 6-7; *cf. Thornburgh*, 476 U.S. at 767 n.12.[14] The threats to

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e.g., Lawall, 307 F.3d at 789-90 (holding that privacy right "applies both when an individual chooses not to disclose highly sensitive information to the government and when an individual seeks assurance that such information will not be made public"); *Sterling v. Borough of Minersville*, 232 F.3d 190, 196-97 (3d Cir. 2000) (holding that a threat of disclosure of confidential information by government official violates individual's privacy right regardless of whether information is actually disclosed); *Ramie v. City of Hedwig Vill.*, 765 F.2d 490, 492 (5th Cir. 1985) (holding that "[t]he disclosure strand of the privacy interest ... includes the right to be free ... from the government inquiring into matters in which it does not have a legitimate and proper concern"). The *Whalen* Court held that such interests were not violated in that case because the required disclosure was much like that required by a prior law and commonly required in the provision of health care. *Whalen*, 429 U.S. at 602. This case presents a sharply different situation because women are not commonly required to reveal their abortion decisions to the state or to provide it with complete copies of their medical records.

[13] R. 61-12 also fails to direct DHEC officials to maintain patient confidentiality, despite the fact that other DHEC regulations include such directives. *See, e.g.*, S.C. CODE ANN. REGS. 61-91 § 1001(D) (2002).

[14] Confidentiality is also important here because the Regulation requires that patient records contain the name of a married abortion patient's husband and the name of a minor abortion patient's parents. R. 61-12 § 401(A)(1). If this information is disclosed, a patient's spouse or parents may learn that she has undergone an abortion. This Court has

patient confidentiality posed by the Regulation may also force women to delay their abortions, undergo illegal abortions or take other actions dangerous to their physical health. *See supra* at 6.

A balancing of these factors tips decidedly in favor of the abortion patients' privacy rights, making clear that the circuit courts' different approaches to informational privacy claims leads to very different results. Moreover, the Fourth Circuit's application of the minority approach in this case leads to an unprecedented result: neither this Court nor any court of appeals has previously upheld an abortion regulation that exposed abortion patients' identities to authorized public disclosure. *Cf., e.g., Casey*, 505 U.S. at 899 (upholding recordkeeping and reporting requirement under which "the identity of each woman who has had an abortion remains confidential"); *Danforth*, 428 U.S. at 80-81 (upholding recordkeeping and reporting requirement because it "properly respect[ed] a patient's confidentiality and privacy"); *Lawall*, 307 F.3d at 788-90 (upholding disclosures to courts in judicial bypass proceedings because the challenged abortion statute explicitly required that the proceedings be confidential and not be made public). It is critical that the Court address this conflict and clarify this area of the law so as to bring uniformity to the federal courts' decision regarding the right to informational privacy.

II. By Rejecting DHEC's Interpretation of the Clergy Provision and Permitting the State to Coerce Participation in Religion, the Decision Below Conflicts With Decisions of this Court and the Courts of Appeals.

The majority's analysis of Plaintiffs' Establishment Clause claim conflicts with the decisions of this Court and

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recognized the prospect of harm that may result from notifying a woman's husband or a minor's parents of her abortion. *Casey*, 505 U.S. at 897; *Bellotti v. Baird*, 443 U.S. 622, 647 (1979).

the Courts of Appeals in three respects. First, the majority erroneously applied the *Salerno* standard to this claim, A9, A12-13; *see United States v. Salerno*, 481 U.S. 739, 745 (1987), despite the fact that this Court analyzes facial Establishment Clause challenges under a less onerous standard, *see, e.g., Santa Fe Indep. Sch. Dist. v. Doe*, 530 U.S. 290, 313-14 (2000). Second, the majority's construction of the clergy provision violates principles of statutory construction and federalism. Finally, the clergy provision, as interpreted by the State, compels abortion providers to support and participate in religion.

A. The Majority Imposed an Impermissible Construction on the Clergy Provision.

DHEC has interpreted the clergy provision to require that abortion providers establish ongoing consulting agreements with clergy so that those clergy are immediately available should the physician wish to refer a patient to them. *Supra* at 5. According to DHEC, abortion providers must make those arrangements with clergy of two or three different denominations, at least one of which must be Protestant. *Id.* DHEC inspectors will then evaluate whether a facility's consulting arrangements and choice of clergy adequately satisfy the Regulation. *Id.* These agency interpretations of the Regulation were presented at trial by George Moore, who is Director of Outpatient and Home Care in DHEC's Division of Licensing, as well as the principal drafter of the Regulation.[15] DHEC and the other State defendants have stood by these interpretations throughout this litigation,[16] defending

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[15] Notably, when the Regulation took effect in October, 2001, it was Mr. Moore, as the Director of Outpatient and Home Care, who was responsible for inspecting Plaintiffs' facilities and ensuring that they were in compliance with the Regulation.

[16] DHEC has never indicated to abortion providers any change in its position; nor has it ever published any contrary interpretation of the clergy provision.

the constitutionality of DHEC's construction of the clergy provision.

Despite this position of the State, the majority below adopted the following construction of the clergy provision:

> [Abortion clinics] are required only to have "arrangements" for referring patients to clergy "as needed." These arrangements might amount to no more than a list of clergy and other specialists or a readily accessible telephone book to consult as required by the needs of a particular patient. Since the need for a referral cannot be known until the patient requests a referral, the 'arrangement' cannot be made until then.

A11. The majority's interpretation not only conflicts with the reasonable interpretation of DHEC, the state agency that drafted and enforces the provision, but it was also expressly rejected by one DHEC inspector who testified that keeping the appropriate sections of a local telephone book on hand would not satisfy the Regulation. A127.[17]

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[17] The majority's construction is also plainly unreasonable. The regulatory language, which requires that "*arrangements shall be made* for consultation or referral services ... *to be available* as needed," R. 61-12 § 307 (emphasis added), cannot reasonably be construed to encompass the essentially passive act of keeping a phone book nearby so that patients can try to find phone numbers for clergy who may or may not be available. The majority's construction is also unreasonable to the extent that it holds that physicians need only make referrals to clergy when a patient requests one. Section 307 requires that physicians make arrangements for consultation "as needed" in: "obstetrics/gynecology, anesthesiology, surgery, psychiatry, psychology, clinical pathology and pathology, clergy, and social services." R. 61-12 § 307. Even a cursory review of this list makes clear that it is the physician, not the patient, who must assess when a referral is needed. If, for example, a referral to an anesthesiologist is appropriate for a particular patient and the physician fails to make a referral because the patient has not asked for one, the physician will likely have committed malpractice. By placing "clergy" in

The majority's complete disregard for DHEC's interpretation conflicts with numerous decisions of this Court and the courts of appeals, which uniformly require that a court give deference to the construction of a regulation by the agency charged with its enforcement so long as that interpretation is not plainly erroneous. *See, e.g., Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994); *Human Dev. Corp. v. United States Dep't of Health & Human Servs.*, 312 F.3d 373, 379 (8th Cir. 2002); *Bldg. Trades Employers' Educ. Ass'n v. McGowan*, 311 F.3d 501, 507 (2d Cir. 2002); *Macias v. N.M. Dep't of Labor*, 21 F.3d 366, 369-70 (10th Cir. 1994); *Rossetti Contracting Co., Inc. v. Brennan*, 508 F.2d 1039, 1042 (7th Cir. 1974); *see also* 1A NORMAN SINGER, SUTHERLAND STATUTORY CONSTRUCTION § 31.6 at 728 (6th ed. 2002).[18] This deference is particularly imperative where, as here, a *federal court* interprets a *state law* that has already been construed by the state agency charged with the law's administration. *Macias*, 21 F.3d at 369 (holding the need for deference "even more compelling" where a federal court is faced with a state agency's interpretation of a state statute); *see also Cuesnongle v. Ramos*, 835 F.2d 1486, 1504 (1st Cir. 1987) (Campbell, C.J., concurring) ("The principle ... that federal courts should not tell state agencies how to interpret state law, is a basic element of our system."); *Huggins v. Isenbarger*, 798 F.2d 203, 209 (7th Cir. 1986) (Easterbrook, J., concurring) ("A federal court owes still greater respect for a state agency's construction of state law"). The majority's approach violates these principles by "inexplicably ig-

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this list, DHEC has indicated that physicians must similarly assess patients' need for clergy referrals. *See Dole v. United Steelworkers*, 494 U.S. 26, 36 (1990) ("words grouped in a list should be given related meaning") (citations omitted).

[18] The South Carolina courts follow an analogous rule. *See, e.g., Brown v. S.C. Dep't of Health & Envtl. Control*, 560 S.E.2d 410, 414 (S.C. 2002); *Converse Power Corp. v. S.C. Dep't of Health & Envtl. Control*, 564 S.E.2d 341, 346 (S.C. Ct. App. 2002).

nor[ing]" the agency's plainly "reasonable interpretation" and imposing a construction that is "plainly implausible." A37-38 (King, J., dissenting).

B. The Clergy Provision Violates the Establishment Clause by Forcing Abortion Providers to Support and Participate in Religion.

Basic to the Constitution's prohibition of the establishment of religion is the assurance that the "government may not coerce anyone to support or participate in religion." *Lee v. Weisman*, 505 U.S. 577, 587 (1992). Pursuant to this principle, this Court in *Lee* invalidated the performance of a nonsectarian prayer by a clergyman at a public school's graduation ceremony. *Id; see also Santa Fe*, 530 U.S. at 310-312 (invalidating student-led, student-initiated prayers at football games because they coerce students to participate in religious observances). The Seventh and Second Circuits have followed *Lee* in striking down prison programs in which inmates' sentences were affected by participation in substance abuse programs that stressed religion. *Warner v. Orange County Dep't of Prob.*, 115 F.3d 1068, 1074-75 (2d Cir. 1996); *Kerr v. Farrey*, 95 F.3d 472 (7th Cir. 1996); *see also Ross v. Keelings*, 2 F. Supp. 2d 810, 816-18 (E.D. Va. 1998). Such programs run "afoul of the prohibition against the state's favoring religion in general over non-religion." *Kerr*, 95 F.3d at 480.

Like the state actions invalidated in *Weisman*, *Santa Fe*, *Kerr*, and *Warner*, the Regulation endorses religion by requiring support of and participation in religion. The clergy provision, as interpreted by DHEC, forces physicians to participate in religion by establishing formal relationships with clergy (including one Protestant), assessing patients' needs for religious counseling, and referring patients for such counseling. By these same means, the provision forces physicians to support religion, regardless of their own spiritual beliefs. It is axiomatic that a physician's referral carries with it an

implication of the physician's belief that the other provider offers a meritorious service or expertise that may assist the patient in preserving or improving her health. *Cf., e.g., Jennings v. Burgess*, 917 S.W.2d 790 (Tex. 1996) (referring physician can be held liable for failing to exercise reasonable care in making a referral); 2 LOUISELL & WILLIAMS, MEDICAL MALPRACTICE ¶ 16.05(1) (Mathew Bender & Co. 2001) (same). A physician's referral to "clergy" necessarily conveys the message that the physician believes that the particular religion or religious personnel, as well as religion in general, have the ability to help the patient's health.

The clergy provision goes far beyond the coercion struck down in *Weisman*, *Santa Fe*, *Kerr*, *Warner*, and *Ross*. Whereas those cases involved the state's inclusion of religious content in programs which plaintiffs planned to attend or were required to attend, South Carolina actually forces physicians to themselves include religious content within their medical practices in order to continue providing abortions. By upholding a Regulation that forces abortion providers to endorse religion generally, and Protestantism in particular, the decision below represents a substantial incursion on the religious freedoms recognized by this Court and the courts of appeals. *See* A42 (King, J., dissenting) (concluding that "[s]uch a referral requirement is unprecedented, and it should be recognized as unconstitutional"); A40 (stating that "[t]his mandatory affiliation ... appears to promote the religious mission of those institutions given referral arrangements"). Certiorari should be granted to resolve these conflicts.[19] *See* SUP. CT. R. 10(a), (c).

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[19] At a minimum, the question of whether the state can require individuals to affiliate with religious personnel, including Protestant personnel, is an important question of federal constitutional law that should be resolved by this Court. SUP. CT. R. 10(c).

III. The Regulation Denies Plaintiffs Due Process of Law By Making Abortion Facility Licensing Contingent Upon the Cooperation of Area Hospitals.

As described above, the Regulation requires, as a prerequisite for licensing, that physicians who provide abortions either have admitting privileges at a local hospital that has successfully sought state certification as an abortion provider, or have a documented transfer arrangement with such a hospital and a written consulting agreement with a physician who has admitting privileges at such a hospital. *See supra* at 5. In either case, the physician must obtain the cooperation of the local hospital, and in either case, the hospital must itself have successfully attempted to become certified by the State as an abortion provider. Nothing in the Regulation or South Carolina law prevents local hospitals from declining to apply for abortion certification or from denying a physician admitting privileges on the basis of the hospitals' opposition to abortion.[20] Thus the Regulation essentially grants hospitals the authority to prevent the licensing of abortion facilities for virtually any reason, including opposition to abortion. Such a delegation of veto power over abortion providers' licenses violates Plaintiffs' right to due process. *See, e.g., Hornsby v. Allen*, 326 F.2d 605, 609-10 (5th Cir. 1964) (holding that licensing decisions must be based upon established standards so that potential licensees are not subject to the uncontrolled discretion of those with licensing authority);

[20] Neither public nor private hospitals are subject to due process limitations in their decision whether to become certified as abortion providers. With respect to admitting privilege decisions, private hospitals in South Carolina are not subject to any due process limitations, *Modaber v. Culpeper Mem'l Hosp.*, 674 F.2d 1023 (4th Cir. 1982), and even in public hospitals, "due process requires only that a public hospital not exclude a physician from practice therein by rules or acts which are unreasonable, arbitrary, capricious or discriminatory," *Huellmantel v. Greenville Hosp. Sys.*, 402 S.E.2d 489, 492 (S.C. Ct. App. 1991). Notably, South Carolina law explicitly protects private hospitals that refuse to permit the performance of abortions in their facilities. S.C. CODE ANN. § 44-41-70 (2002).

see also Hallmark Clinic v. N.C. Dep't of Human Res., 380 F. Supp. 1153, 1158-59 (E.D.N.C. 1974) (three-judge district court) ("If the state is determined to utilize hospitals as a control factor for the protection of patients in freestanding abortion clinics then it must establish and enforce standards for admission to hospital staff privileges. To do otherwise is government by caprice and cannot withstand fourteenth amendment challenge.").

The majority rejected this claim on the sole ground that the challenged provisions have not yet prevented Plaintiffs from obtaining licenses. A9. This holding conflicts with decisions of this Court and the Fifth Circuit, which recognize that the delegation of standardless authority itself denies due process to the persons subject to that authority.[21] *See City of Eastlake v. Forest City Enters., Inc.*, 426 U.S. 668, 677 (1976) (holding that due process is violated when "the delegation of legislative power, originally given by the people to a legislative body, ... [is] in turn delegated by the legislature to a narrow segment of the community"); *Washington ex rel. Seattle Title Trust Co. v. Roberge*, 278 U.S. 116, 121-23 (1928) (striking down ordinance permitting the establishment of homes for the aged in residential areas only upon the written consent of the owners of two-thirds of the property within 400 feet of the proposed facility because "the delegation of power so attempted is repugnant to the due process

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[21] The majority relied heavily upon an Eighth Circuit decision that did not involve abortion facility licensing. *Women's Health Ctr. of West County, Inc. v. Webster*, 871 F.2d 1377, 1382 (8th Cir. 1989). The Eighth Circuit's holding rests on its erroneous equation of admitting privilege requirements with requirements that abortion providers hold a license to practice medicine. *Id.* The two types of requirements cannot be equated for due process purposes because professional licensing boards, unlike hospitals ruling on admitting privileges, must make their decisions on the basis of individual merit and cannot deny licenses on the basis of their own disfavor of lawful and constitutionally protected practices. *See, e.g., Schware v. Bd. of Bar Exam'rs*, 353 U.S. 232, 238-39 (1957).

clause"); *Causeway Med. Suite v. Ieyoub*, 109 F.3d 1096, 1110 (5th Cir. 1997) (striking down a delegation of standardless veto power over minors' abortions to judges, and explaining that "this discretion itself, and not the exercise of it" is unconstitutional); *see also Birth Control Ctrs., Inc. v. Reizen*, 508 F. Supp. 1366, 1374-75 (E.D. Mich. 1981) (invalidating similar requirement "[e]ven though plaintiff clinics encountered no problems in obtaining ... transfer agreements," because the constitutional "defect lies in the delegation of unguided power to a private entity"), *aff'd in part & vacated in part on other grounds*, 743 F.2d 352 (6th Cir. 1984); *Hallmark*, 380 F. Supp. at 1158-59 (striking down a similar requirement that abortion providers have hospital transfer agreements or admitting privileges because that delegation had the "potential for arbitrariness"). Because the opinion below interprets the requirements of due process in a way that conflicts with decisions of this Court and various courts of appeals, certiorari should be granted.[22] *See* SUP. CT. R. 10(a), (c).

IV. The Majority Erroneously Applied the *Salerno* Standard to Plaintiffs' Vagueness Challenge and Upheld Hopelessly Vague Provisions.

The majority rejected Plaintiffs' vagueness claims under the stringent "no set of circumstances" test set forth in *United States v. Salerno*, 481 U.S. 739, 745 (1987). *See* A9, A17-19.[23] This approach conflicts with this Court's decision in

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[22] The issue of whether a standardless delegation of government authority violates due process regardless of the improper exercise of the delegated authority is also an important question of federal constitutional law that should be resolved by this Court. SUP. CT. R. 10(c).

[23] The majority also erroneously implies that purported similarities between the Regulation's requirements and guidelines of the American College of Obstetricians and Gynecologists are relevant to the court's vagueness analysis. This is clearly incorrect for the guidelines referenced are not law, are non-binding, and are "general and intended to be adapted to many different situations." A153.

Kolender v. Lawson, which held that the *Salerno* standard does not apply in a vagueness challenge to a law that reaches constitutionally protected conduct or imposes criminal penalties. *Kolender v. Lawson*, 461 U.S. 352, 359 n.8 (1983) (rejecting contention that statute should not be held vague on its face unless it is vague in all its applications); *see also, e.g., Houston v. Hill*, 482 U.S. 451, 458-59 (1987); *Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 494 (1982); *Colautti v. Franklin*, 439 U.S. 379, 394-401 (1979); *Planned Parenthood v. Farmer*, 220 F.3d 127, 135 (3d Cir. 2000); *United States v. Gaudreau*, 860 F.2d 357, 360 (10th Cir. 1988). Because the Regulation governs constitutionally protected conduct and imposes criminal penalties,[24] the majority's application of *Salerno* was plainly incorrect.

Section 103(c) of the Regulation must be stricken under the applicable standard of vagueness review. That provision subjects abortion providers to penalties for failing to comply with "best practices" that have not been promulgated, written down or articulated in any form, but will instead be defined by DHEC inspectors on a case-by-case basis.[25] The term "best practices" can be interpreted by DHEC inspectors to include limitless requirements with which abortion providers must comply in order to avoid sanctions. This is the epitome of a vague law. The fact that a DHEC inspector will articulate the requirements of such "best practices" when ordering compliance with them does not remedy the constitutional infirmity. As this Court held in *City of Chicago v. Morales*, a standardless prohibition is not cured by the fact that law enforcement will later "fill in" the content of the prohibition. 527 U.S. 41, 56-60 (1999). Thus, § 103(c) fails to give fair

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[24] *See* S.C. CODE ANN. § 44-7-340 (2002).

[25] The majority's assumption that this provision merely allows DHEC to promulgate new regulations is contrary to DHEC's position that inspectors will define "best practices" on a "case by case basis" and can cite a provider for a Class III violation if he or she is not in compliance with a best practice defined by a DHEC inspector. A141-142.

notice of the conduct it prohibits and lacks standards to prevent arbitrary or discriminatory enforcement, and the decision below conflicts with this Court's decisions in *Morales*, 527 U.S. 41, *Hoffman Estates*, 455 U.S. at 498-99, *Colautti*, 439 U.S. at 391, and *Grayned v. City of Rockford*, 408 U.S. 104, 108-09 (1972). Certiorari should be granted to resolve these conflicts. *See* SUP. CT. R. 10(a), (c).

CONCLUSION

For the foregoing reasons, Petitioners respectfully request that the Court grant their petition for a writ of certiorari.

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Dated: February 12, 2003

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No. 02-1235

In The
Supreme Court of the United States

GREENVILLE WOMEN'S CLINIC;
WILLIAM LYNN, M.D., ON BEHALF OF THEMSELVES
AND THEIR PATIENTS SEEKING ABORTIONS,

Petitioners,

v.

COMMISSIONER, SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL
CONTROL; GOVERNOR OF SOUTH CAROLINA;
CHARLES MOLONY CONDON, IN HIS OFFICIAL
CAPACITY AS ATTORNEY GENERAL OF THE
STATE OF SOUTH CAROLINA,

Respondents.

On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Fourth Circuit

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

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United States Court of Appeals,
Fourth Circuit.

GREENVILLE WOMEN'S CLINIC; William Lynn, MD, on behalf of themselves and their patients seeking abortions, Plaintiffs-Appellants,
and
Charleston Women's Medical Clinic, Incorporated, Plaintiff,

v.

COMMISSIONER, SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL; Governor of South Carolina; Charles Molony Condon, in his official capacity as Attorney General of the State of South Carolina, Defendants-Appellees.

GREENVILLE WOMEN'S CLINIC; William Lynn, MD, on behalf of themselves and their patients seeking abortions, Plaintiffs-Appellees,
and
Charleston Women's Medical Clinic, Incorporated, Plaintiff,

v.

Commissioner, South Carolina Department of Health and Environmental Control;

Governor of South Carolina; Charles Molony Condon, in his official capacity as Attorney General of the State of South Carolina, Defendants-Appellants.

Nos. 01-2090, 01-2235.

Argued Apr. 5, 2002.
Decided Sept. 19, 2002.

Appeals from the United States District Court for the District of South Carolina, at Greenville. Henry M. Herlong, Jr., District Judge. (CA-96-1898-6-20).

ARGUED: Bonnie Scott Jones, THE CENTER FOR REPRODUCTIVE LAW & POLICY, New York, New York, for Appellants. Boyd Benjamin Nicholson, Jr., HAYNSWORTH, SINKLER, BOYD, P.A., Greenville, South Carolina, for Appellees. **ON BRIEF:** Randall Scott Hiller, Greenville, South Carolina, for Appellants. George Dewey Oxner, Jr., Floyd Matlock Elliott, HAYNSWORTH, SINKLER, BOYD, P.A., Greenville, South Carolina; Charles Molony Condon, James Emory Smith, Jr., OFFICE OF THE ATTORNEY GENERAL, Columbia, South Carolina; Nancy Staats Layman, DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL, Columbia, South Carolina, for Appellees.

Before NIEMEYER and KING, Circuit Judges, and JAMES H. MICHAEL, JR., Senior United States District Judge for the Western District of Virginia, sitting by designation.

Affirmed in part and reversed in part by published opinion. Judge NIEMEYER wrote the opinion, in which

Senior Judge MICHAEL joined. Judge KING wrote a dissenting opinion.

OPINION

NIEMEYER, Circuit Judge.

***1** This appeal continues our review of the facial constitutional challenges made by abortion clinics in South Carolina to Regulation 61-12 of the South Carolina Department of Health and Environmental Control, establishing standards for licensing abortion clinics. In *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000), *cert. denied*, 531 U.S. 1191 (2001) ("*Bryant I*"), we held (1) that Regulation 61-12 did not place an undue burden on a woman's decision whether to seek an abortion in violation of the liberty interest protected by the Due Process Clause and (2) that the regulation did not distinguish unreasonably between clinics that performed a specified number of abortions and those that did not in violation of the Equal Protection Clause.

On remand, the district court addressed the remaining challenges made to Regulation 61-12, rejecting the abortion clinics' contentions that the regulation unconstitutionally delegates licensing authority to nongovernmental third parties without standards; that it violates the Establishment Clause of the First Amendment; and that it is void for vagueness. The district court did, however, conclude that § 102(F) of the regulation, which provides South Carolina inspectors access to records of abortion clinic patients, infringes on a constitutional right to informational privacy insofar as it authorizes the disclosure of patients' names to State inspectors.

On the cross-appeals of the parties, we reject all of the remaining constitutional challenges to Regulation 61-12 and accordingly affirm in part and reverse in part.

I

As authorized in §§ 44-41-10 *et seq.* and 44-7-110 *et seq.* of the Code of Laws of South Carolina, the South Carolina Department of Health and Environmental Control ("DHEC") promulgated Regulation 61-12, entitled "Standards for Licensing Abortion Clinics." Because Regulation 61-12, which comprehensively regulates abortion clinics in South Carolina, was summarized more fully in *Bryant I,* 222 F.3d at 160-62, we only briefly summarize its ten chapters here:

Chapter 1, entitled "Definitions and Requirements for Licensure," includes definitions of relevant terms and sets forth the general requirement that abortion clinics in South Carolina be licensed and subject to inspections. A regulated abortion clinic is defined as "[a]ny facility, other than a hospital as defined in Section 101.J, in which any second trimester or five or more first trimester abortions per month are performed." DHEC Reg. 61-12, § 101(B). Any facility in violation of the regulation may be subjected to civil penalties, including suspension or revocation of its license or a monetary fine. *Id.* § 103.

Chapter 2, entitled "Administration and Management," describes operational policies and procedures, as well as personnel requirements. It also includes a summary of the patients' rights. *Id.* § 209.

Chapter 3, entitled "Patient Care," prescribes minimum procedures required in the treatment of all patients and a limitation of the procedures that may be provided at the facility. The chapter includes admissions criteria, staff responsibilities, and details regarding abortion procedure and follow-up care. *Id.* § 301. Also included within this chapter are certain facility requirements, such as pharmaceutical capabilities and laboratories. *Id.* §§ 303, 304. There is a specification of minimum equipment and supplies, *id.* § 306, and a requirement that clinics implement an ongoing plan for improvement of patient care, *id.* § 308. The chapter further specifies that for purposes of emergency care, staff or con-

sulting physicians shall have admitting privileges at a local hospital that has appropriate obstetrical and gynecological services. *Id.* § 305. Finally, the chapter requires that abortion clinics make arrangements for consultation or referral services "in the specialties of obstetrics/gynecology, anesthesiology, surgery, psychiatry, psychology, clinical pathology and pathology, clergy, and social services, as well as any other indicated field, to be available as needed." *Id.* § 307.

*2 Chapter 4, entitled "Medical Records and Reports," sets forth detailed requirements for the generation of patient records, which must be maintained and stored in a "safe location" for at least ten years. *Id.* §§ 401, 402. This chapter also requires abortion clinics to report to the appropriate State agency each abortion performed, each "fetal death" when the fetus has developed beyond a certain stage, and each "accident or incident occurring in the facility which involves patients, staff, or visitors." *Id.* § 403.

Chapter 5, entitled "Functional Safety and Maintenance," deals with safety in clinics' handling of hazardous materials, needles, syringes, and similar materials. *Id.* § 501. It also requires the maintenance of emergency equipment and a plan for disaster preparedness. *Id.* §§ 502, 503.

Chapter 6, entitled "Infection Control and Sanitation," describes procedures for maintaining sterilized supplies and equipment, as well as requirements for having clean linen and towels, clean facilities and grounds, and waste disposal.

Chapter 7, entitled "Fire Protection and Prevention," details specific requirements for fire protection and safety, including mandatory fire drills and alarm testing.

Chapter 8, entitled "Design and Construction," sets forth requirements for approval of the design and construction of abortion clinics and includes requirements for specific types of rooms, security, and equipment.

Chapter 9, entitled "Prerequisites for Initial Licensure," includes the requirements for plan and construction approval,

the existence of documentation demonstrating licensure, and the necessary facility permits.

Finally, Chapter 10, entitled "General," states in its entirety, "Conditions arising that have not been addressed in these regulations shall be managed in accordance with the best practices as interpreted by the Department."

On June 27, 1996, one day before Regulation 61-12 was to become effective, the plaintiffs — two abortion clinics and a doctor operating abortion clinics — commenced this action on behalf of themselves and their patients to obtain a declaratory judgment that Regulation 61-12 was facially unconstitutional on numerous grounds. The district court agreed with the plaintiffs in part, finding that Regulation 61-12 placed an undue burden on a woman's Fourteenth Amendment due process right to choose whether to seek an abortion and that the regulation violated the Equal Protection Clause of the Fourteenth Amendment by treating abortion clinics differently than other healthcare facilities without a rational basis for doing so. *Greenville Women's Clinic v. Bryant,* 66 F. Supp.2d 691 (D.S.C. 1999). Because the district court struck down the regulation on two different grounds, it did not decide the plaintiffs' other constitutional challenges.

On appeal, we reversed, holding that Regulation 61-12 did not impose an undue burden on a woman's right to choose whether to seek an abortion and that South Carolina had a rational basis for treating abortion clinics differently from other medical facilities. *Bryant I,* 222 F.3d at 171-72, 174. We found that Regulation 61-12 serves a valid purpose in safeguarding the health of women and does not aim directly at a woman's right to make the decision to have an abortion. The $23-$75 increased cost per abortion attributable to compliance with Regulation 61-12 was, we held, an incidental effect that, while making abortions modestly more expensive, did not unduly burden a woman's right to make the abortion decision. *Id.* at 169-72. Because the regulation did not strike at the abortion-decision right itself, we also ap-

plied a rational-basis standard to the equal protection analysis and concluded that South Carolina had a rational basis for regulating abortion clinics while not regulating other healthcare facilities. We noted that abortions are "inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life." *Id.* at 174 (quoting *Harris v. McRae,* 448 U.S. 297, 325 (1980) (emphasis omitted)). At bottom, we concluded that "[a] woman in South Carolina who has determined to abort the life of a fetus can do so without significant interference from South Carolina's regulations and be assured thereby of a dignified and safe procedure." *Id.* at 175.

*3 After the Supreme Court denied the plaintiffs' petition for a writ of certiorari, *see* 531 U.S. 1191 (2001), we remanded the case to the district court to address the plaintiffs' other constitutional challenges.

On remand, the district court rejected all but one of the plaintiffs' other constitutional challenges, concluding that Regulation 61-12 did not improperly delegate veto power to third parties; that it did not violate the Establishment Clause of the First Amendment; and that it was not unconstitutionally vague. The Court did, however, find that § 102(F)(2) violated patients' right to privacy insofar as it authorized State inspectors access to patients' records in which the patients were identified. Greenville Women's Clinic and William Lynn, M.D. (hereafter, "the abortion clinics") appealed the district court's rulings upholding the constitutionality of Regulation 61-12, and South Carolina cross-appealed the district court's ruling finding § 102(F)(2) in violation of patients' privacy rights.

II

The abortion clinics contend first that Regulation 61-12 provides for the standardless delegation of licensing authority to third persons, in violation of the Due Process Clause. They assert that the regulation makes licensing "contingent upon the cooperation of hospitals, clergy and other third par-

ties, upon whose decisions the regulation imposes no standard or limitation." To support this argument, they rely on *Yick Wo v. Hopkins,* 118 U.S. 356, 370 (1886), and *Hornsby v. Allen,* 326 F.2d 605, 608 (5th Cir. 1964).

Although Regulation 61-12 does not directly grant any veto power to third persons over the issuance of a license, it does require, as a condition of licensure, that clinic doctors maintain certain admitting rights with local hospitals and referral arrangements with other relevant experts. Specifically, Regulation 61-12 requires (1) that each abortion clinic have an agreement with a physician board-certified in obstetrics and gynecology who has admitting privileges at a local hospital to be available during "operating-hours," DHEC Reg. 61-12, § 205(c)(2); (2) that a physician at the clinic have admitting privileges at a local hospital with "obstetrical/gynecological services," *id.* § 305(A); *see also id.* § 309(B); and (3) that each abortion clinic make arrangements for referral services "in the specialties of obstetrics/gynecology, anesthesiology, surgery, psychiatry, psychology, clinical pathology and pathology, clergy, and social services, as well as any other indicated field, to be available as needed," *id.* § 307.

South Carolina argues that these admitting privileges and referral arrangements are necessary for the health and safety of patients. Moreover, it points out that these requirements are consistent with existing standards of the American College of Obstetricians and Gynecologists, as stated in its "Standards for Obstetric-Gynecologic Services" (7th ed. 1995), and of the National Abortion Federation, as stated in its "Standards for Abortion Care" (1988). It also denies that the regulation gives any of the third party specialists a veto power over licensure of abortion clinics and notes that, in practice, the abortion clinics' fears about being denied a license or losing their license because of any inability to establish such arrangements are not supported by the record. Indeed, both Greenville Women's Clinic and Dr. Lynn, the

appellants in this case, are already licensed in South Carolina to perform abortions, and both have admitting privileges or arrangements with physicians who have admitting privileges at local hospitals with obstetrical and gynecological services. This evidence, South Carolina argues, is "fatal" to the abortion clinics' position.

*4 We begin by emphasizing, as we did in *Bryant I,* that the challenge to Regulation 61-12 is a facial one and therefore "the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid." *United States v. Salerno,* 481 U.S. 739, 745 (1987). To show the necessary respect to legislative departments, particularly in light of Article III's limitation of judicial power to cases and controversies, we require evidence — as opposed to speculation — sufficient to rebut the regulation's presumptive constitutionality. Yet, in this record, we find only speculation.

There is nothing in the record or, indeed, in the general experience in South Carolina that suggests that the requirements to have admitting arrangements with local hospitals and referral arrangements with local experts in various related fields present a substantial impediment to obtaining or retaining a license. To the contrary, the appellants in this case have obtained licenses and have made such arrangements. The abortion clinics' asserted fears are further undermined by South Carolina's requirement that public hospitals not act unreasonably, arbitrarily, capriciously, or discriminatorily in granting or denying admitting privileges. *See, e.g., In re Zaman,* 329 S.E.2d 436, 437 (S.C. 1985); *cf. Huellmantel v. Greenville Hosp. Sys.,* 402 S.E.2d 489, 491 (S.C. Ct. App. 1991) (stating that a physician's interest in being reappointed to a public hospital staff is protected by procedural and substantive due process requirements of the Fourteenth Amendment). The required referral arrangements present even lower practical barriers. Indeed, they are re-

quired to be made only "as needed." *See* DHEC Reg. 61-12, § 307.

These requirements of having admitting privileges at local hospitals and referral arrangements with local experts are so obviously beneficial to patients, *see, e.g., Women's Health Ctr. of West County, Inc. v. Webster,* 871 F.2d 1377, 1382 (8th Cir. 1989), and the possibility that the requirements will amount to a third-party veto power is so remote that, on a facial challenge, we cannot conclude that the statute denies the abortion clinics due process. *See Whalen v. Roe,* 429 U.S. 589, 601-02 (1977) (noting that, on a facial challenge of a statute, a "remote possibility" is "not a sufficient reason for invalidating" a statute); *see also Webster,* 871 F.2d at 1382 (rejecting due process challenge to a statute requiring physicians performing abortions to have surgical privileges at a hospital). This conclusion is further reinforced by the right given by Regulation 61-12, § 102(L), for clinics to seek a waiver or exception.

Accordingly, we reject the abortion clinics' due process challenge to Regulation 61-12 based on the regulation's requirement that abortion clinics have admitting privileges to local hospitals and referral arrangements with relevant experts.

III

The abortion clinics also contend that § 307 of Regulation 61-12 is a State-sponsored "law respecting an establishment of religion," as prohibited by the First and Fourteenth Amendments. Section 307 provides in relevant part:

> Arrangements shall be made for consultation or referral services in the specialties of ... clergy ..., to be available as needed.

***5** The abortion clinics contend that this section requires that the clinics "establish formal, ongoing relationships with clergy persons who will be available to provide counseling services to their patients upon referral." And they

argue that "[u]nder the provision, [the abortion clinics] must assess their patients' need for religious counseling and make referrals to such counseling as part of their practice of medicine. To enforce the regulation, DHEC must assess the adequacy of [the abortion clinics'] criteria and mechanisms for making such referrals." Relying on this reading of § 307, the abortion clinics maintain that the regulation violates the Establishment Clause of the First Amendment because (1) it coerces participation in religion; (2) it improperly entangles the State in religion; and (3) it creates "a symbolic union between church and state."

We conclude, however, that the abortion clinics' argument is grounded on a substantial misreading of § 307, imputing obligations and relationships that are not prescribed by the regulation. Section 307 does not require abortion clinics to become involved in religion, or to counsel their patients in religion, or to make any religious judgments. Rather, they are required only to have "arrangements" for referring patients to clergy "as needed." These arrangements might amount to no more than a list of clergy and other specialists or a readily accessible telephone book to consult as required by the needs of a particular patient. Since the need for a referral cannot be known until the patient requests a referral, the "arrangement" cannot be made until then. And even then it need not involve more than a communication to a clergy member expressing the patient's request and perhaps setting up a consultation time.

The requirements of § 307 simply cannot be construed to "force physicians to participate in religion," or to "assess patients' needs for religious counseling," or to "force physicians to support religion" — as the abortion clinics in this case argue. Moreover, the language of the regulation does not support the abortion clinics' contention that the DHEC may evaluate whether abortion clinics have established an adequate system, adequate number, or adequate variety of clergy to whom referrals might be made. Finally, § 307 does

not grant the religious community any veto power over the clinic's licensing application "thus creating a symbolic union between church and state." Because the section calls for arrangements "as needed," a clinic need not assist the patient by making a referral to clergy unless the patient so requests.

*6 Rather than establishing religion, this section would appear at most to require a clinic to accommodate the requests of patients to exercise religion, a right also protected by the First Amendment. *See* U.S. CONST. amend. I (forbidding any law that "prohibits the free exercise" of religion). Particularly because of the gravity of a woman's right to make the abortion decision, the regulation recognizes the patient's potential desire to consult clergy in making that decision. As the Supreme Court observed in *Planned Parenthood of S.E. Penn. v. Casey,* "the abortion decision ... is more than a philosophic exercise. Abortion is a unique act [that is] fraught with consequences." 505 U.S. 833, 852 (1992). And similarly, we observed in *Bryant I:*

> As humankind is the most gifted of living creatures and the mystery of human procreation remains one of life's most awesome events, so it follows that the deliberate interference with the process of human birth provokes unanswerable questions, unpredictable emotions, and unintended social and, often, personal consequences beyond simply the medical ones.

222 F.3d at 175.

Accordingly, we conclude that the requirement imposed by § 307 on abortion clinics to make arrangements for referral services to clergy, as needed, does not, on its face, establish religion in violation of the First Amendment. *Cf. Brown v. Gilmore,* 258 F.3d 265 (4th Cir. 2001) (holding that a State statute requiring a moment of silence to enable students to meditate, *pray,* or engage in any other silent activity does not

establish religion in violation of the First Amendment), *cert. denied,* 122 S. Ct. 465 (2001). In so concluding, we note that this facial challenge cannot encompass every way in which the DHEC might require a clinic to comply with § 307. Specific instances of enforcement may, of course, still be challenged on a case-by-case basis as they occur.

IV

Finally, the abortion clinics contend that Regulation 61-12 is void for vagueness, in violation of the Due Process Clause. They contend that the regulation contains a number of requirements that employ "open-ended" terms lacking any fixed meaning, such as "best practice" or "case-by-case" basis. They maintain that the regulation uses ambiguous adjectives, such as "intensive job-related training," which qualifies a non-physician for work at a clinic. They assert that the regulation contains misnomers, giving as an example that the facilities must be kept "neat, clean and free from odors" and noting that because every medical office has odors, the regulation cannot mean what it says. Finally, they point to inherently ambiguous requirements such as the requirement that "all staff *and/or* consulting physicians shall have admitting privileges at one or more local hospitals." The abortion clinics have identified the following list of provisions that they challenge, and they suggest that this list is not exhaustive:

> *7 1. Section 102(J), which prohibits using an abortion facility name that is similar to the name of another such facility, but does not define how "similarity" will be determined.
>
> 2. Section 102(L), which allows DHEC to make exceptions to Regulation 61-12 "where it is determined that the health and welfare of the community require the services of the facility."

3. Section 103(F), which gives DHEC discretion with respect to a particular violation to impose any penalty within the range of possible penalties.

4. Section 201(B), which requires abortion providers to create, and DHEC to assess, policies and procedures on such matters as "patient rights" and "functional safety."

5. Section 204, which requires that staff be "adequately trained and capable of providing appropriate service and supervision to the patients."

6. Section 204(A), which requires that a provider "verify" an employee's "health and personal background."

7. Section 204(D), which prohibits employees and volunteers with "any ... contagious disease or illness [from working] in any capacity in which there is a likelihood of such person transmitting disease to other individuals."

8. Section 205(C)(1), which requires physicians performing abortions to be "properly qualified by training and experience to perform pregnancy termination procedures."

9. Section 301, which requires the creation of various policies and procedures "designed to ensure professional and safe care for patients."

10. Section 305(A), which requires that "all staff and/or consulting physicians shall have

admitting privileges at one or more local hospitals."

11. Section 306, which requires that "appropriate equipment and supplies" be maintained, with no specific requirements.

12. Section 307, which requires among the required consultation services, "any other indicated field, to be available as needed."

13. Sections 308(A) and (C), which require abortion facilities to establish a quality improvement plan that involves "criteria-based" evaluation of patient care.

14. Section 501(A), which requires abortion facilities to promulgate a range of policies and procedures "to enhance safety."

15. Section 602(A), which requires adequate space for sterile supplies and equipment.

16. Section 604, which requires that the facilities "be kept neat, clean and free from odors."

17. Section 606, which requires that "all outside areas ... shall be kept free of ... grass ... that may serve ... as a haven for insects."

18. Section 807, which requires that an "adequate number of examination/procedure rooms" and an "adequate number of recovery rooms" be provided.

19. Chapter 10, which states in its entirety, that "[c]onditions arising that have not been

> addressed in these regulations shall be managed in accordance with the best practices as interpreted by the Department."

In sum, the abortion clinics complain that Regulation 61-12 does not provide sufficient specifics to explain what conduct is actually mandated or prohibited.

***8** The district court reviewed the abortion clinics' "litany of phrases which [were] allegedly unconstitutionally vague," and after considering the phrases in their context and taking Regulation 61-12 as a whole, the court concluded that "people of ordinary intelligence would be able to understand what the regulation requires." The court also stated that the regulation "does not encourage arbitrary and discriminatory enforcement. In fact, it appears that the majority of Regulation 61-12 is identical to the American College of Obstetricians and Gynecologists ("ACOG") standards for obstetricians and gynecologists."

"A statute can be impermissibly vague for either of two independent reasons. First, if it fails to provide people of ordinary intelligence a reasonable opportunity to understand what conduct it prohibits. Second, if it authorizes or even encourages arbitrary and discriminatory enforcement." *Hill v. Colorado,* 530 U.S. 703, 732 (2000). But because we are "condemned to the use of words, we can never expect mathematical certainty from our language." *Grayned v. City of Rockford,* 408 U.S. 104, 110 (1972). As such, a regulation is not void for vagueness unless it is so unclear with regard to what conduct is prohibited that it "may trap the innocent by not providing fair warning," or it is so standardless that it enables "arbitrary and discriminatory enforcement." *Id.* at 108. Furthermore, the degree of clarity required depends on the type of regulation:

> Economic regulation is subject to a less strict vagueness test because its subject matter is often more narrow, and because businesses ...

> can be expected to consult relevant legislation in advance of action.... The Court has also expressed greater tolerance of enactments with civil rather than criminal penalties because the consequences of imprecision are qualitatively less severe.

Village of Hoffman Estates v. Flipside, Hoffman Estates, Inc., 455 U.S. 489, 498-99 (1982) (footnotes omitted).

Although portions of Regulation 61-12 fall short of mathematical precision, we are satisfied that a reasonable person, reading the regulation in its entirety and in the context of South Carolina statutes, would be able to interpret the regulation and determine what is required and what conduct is prohibited. For example, § 205(C)(1), the violation of which would allow the most serious penalty of the sections identified as vague by the abortion clinics, provides that abortion-clinic physicians be "properly qualified by training and experience to perform pregnancy termination procedures." The abortion clinics argue that they do not understand how physicians need to be qualified to satisfy this provision. Yet, physicians routinely hold themselves out as qualified to practice in given areas based on their training and experience, and such a standard is routinely applied in the medical field to define whether a physician breached the ordinary standard of care or whether a physician is competent to perform a specialized surgery. *See, e.g., Hoeffner v. The Citadel,* 429 S.E.2d 190, 192 (S.C. 1993) (requiring expert testimony to determine defendant doctor's standard of care and breach thereof). In short, physicians have no difficulty in stating that they are qualified by training and experience to practice in a given area or to perform specified procedures. We believe that the other challenged provisions can similarly be followed by reasonably prudent abortion providers who are mindful of their patients' health and safety.

***9** The most unclear provision in Regulation 61-12 may be Chapter 10, which provides that "[c]onditions arising

that have not been addressed in these regulations shall be managed in accordance with the best practices as interpreted by the Department." But this provision essentially appears to give the DHEC no power beyond its ability to promulgate further regulations as they become necessary. Moreover, any violation of Chapter 10 could only amount to a "Class III" violation, which would call for nothing more than a warning sanction. Accordingly, we can see no reason to conclude that the imprecision of this particular provision violates the abortion clinics' due process rights.

In addition to concluding that persons of reasonable intelligence would be able to understand what is required of them by Regulation 61-12, we note that the penalties are civil rather than criminal. Regulation 61-12 divides its penalties into three classes, and a Class I offense, the most serious, is subject, on the first offense, to a maximum fine of $1,000. DHEC Reg. 61-12, § 103(F). A Class II offense is subject, on the first offense, to a maximum fine of $500, *id.*, and a Class III offense, on the first offense can lead at most, to a warning, *id.* Even when a fine is called for, there are suggested factors for determining the amount, including the facility's efforts to correct the identified problem, the facility's overall conditions, and the facility's history of compliance. *Id.* § 103(E). This consideration of the violator's good faith effort to comply makes arbitrary enforcement even less likely. Moreover, as observed in *Village of Hoffman Estates,* we can expect abortion clinics to consult relevant legislation in advance of action or to seek clarification from appropriate administrative sources when necessary. *See* 455 U.S. at 498.

In the context of a facial challenge to a regulation, it is inappropriate to speculate regarding a worst-case scenario. *See Hill,* 530 U.S. at 733 (noting that "speculation about possible vagueness and hypothetical situations not before the Court will not support a facial attack on a statute when it is surely valid 'in the vast majority of its intended applications'" (quoting *United States v. Raines,* 362 U.S. 17, 23

(1960))). Accordingly, we affirm the district court's conclusion that Regulation 61-12 is not unconstitutionally vague.

V

South Carolina, in its cross-appeal, challenges the district court's ruling that § 102(F)(2) of Regulation 61-12 is unconstitutional. That section provides: "Department inspectors shall have access to all properties and areas, objects, records and reports, and shall have the authority to make photocopies of those documents required in the course of inspections or investigations." The district court stated that because South Carolina identified "no compelling interest in the disclosure of identifying information" — i.e., information that reveals to the State the names of patients procuring abortions — § 102(F)(2) violates the patient's constitutional right to privacy "insofar as it requires access to identifying information." In a footnote, the court allowed that "[t]his constitutional problem can be cured by the plaintiffs redacting the documents to remove such information." South Carolina contends that, notwithstanding the district court's conclusion, it needs the information to monitor abortions and to assure compliance with the health-care standards in Regulation 61-12 aimed at preserving maternal health. It notes that even the National Abortion Federation, in its "Standards for Abortion Care," states that the "maintenance of complete and accurate records is essential for quality patient care and meaningful review of services." The Federation's "Standards of Abortion Care" explains that the "reporting of abortion procedures and complications to appropriate private and legally sanctioned public agencies generally improve[s] family planning services and public health information." In addition, South Carolina argues that its statutes and regulations provide adequately for the privacy of patients' records.

***10** The abortion clinics contend, on the other hand, that disclosure of patients' names and records violates the patients' privacy rights as defined in *Whalen v. Roe,* 429 U.S. 589, 597 (1977) (recognizing a right to privacy "in avoiding

disclosure of personal matters"), and *Walls v. City of Petersburg*, 895 F.2d 188, 192 (4th Cir. 1990) (requiring the State to offer a "compelling" interest before disclosing protected information). They argue that the confidentiality of patient information is "vital to women seeking abortions because they may face harassment from their partners, co-workers, and others for having decided to undergo an abortion." And they maintain that disclosing the information also "may force patients to delay their abortions until they can go to a state where their confidentiality will be maintained; to go to an unlicenced provider; or to attempt to self-abort [sic]. Each of these alternatives poses serious risks to patient health."

South Carolina's abortion statute requires that each abortion be reported to the DHEC within seven days after the abortion is performed. *See* S.C. Code Ann. § 44-41-60. The same statute authorizes the DHEC to promulgate regulations for the maintenance of medical records and reports. *See id.* §§ 44-41-70, 44-41-75.

To carry out its mandate, the DHEC promulgated Regulation 61-12, comprehensively providing for the generation and maintenance of records and reporting as necessary to carry out the licensing and regulation of abortion clinics. Regulation 61-12 requires that written consent be obtained from each patient obtaining an abortion and that a copy of the consent be maintained in the patient's record. *See* DHEC Reg. 61-12, § 201(b)(10). The regulation prescribes a list of items that must be included in patients' medical records relating to any abortion procedure performed and requires that the records be maintained in a safe location for a minimum of ten years. *See id.* §§ 401, 402. It also requires that each laboratory test be documented in a report and maintained as part of the patient's record. *See id.* § 304(E). With respect to each employee at an abortion clinic, Regulation 61-12 requires that the clinic maintain a personnel file, documenting the employee's job description, work assignments, in-service education, licensure, if applicable,

and tuberculosis skin-testing. *See id.* § 204(H). In-service training programs, providing employees training in specified areas at least once annually, must also be documented, reflecting the program's contents and attendance. *See id.* § 204(F). The regulation also requires that clinics maintain records of all controlled substances. *See id.* § 303(F). It mandates that the clinics conduct sterilization procedures and maintain records of those procedures, as well as safety-testing equipment and alarms. *See id.* §§ 602(C), 702. And the regulation requires that the clinic maintain on its premises the documentation evidencing its licensure in a manner sufficient to inform patients. *See, e.g., id.* §§ 203, 208, 209.

***11** In addition to its requirements for generating and maintaining records, Regulation 61-12 imposes reporting requirements. Abortion clinics must report each abortion and each accident or incident to the Vital Records and Public Health Statistics section of the DHEC. *See id.* § 403. In addition, the abortion clinics are subject to regular inspections, and DHEC inspectors are given access to all "records and reports" and authority to make photocopies of those documents "required in the course of inspections or investigations." *See id.* § 102(F)(2).

The abortion clinics do not seriously challenge the requirement of generating and maintaining records. Indeed, they would have to acknowledge that each type of record relates directly to the health or safety requirements imposed by Regulation 61-12. And the Supreme Court has found that requiring documentation of this type is in the public interest and does not violate any constitutional right to privacy. *See Whalen v. Roe,* 429 U.S. 589 (1977); *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52 (1976).

In *Whalen,* the Supreme Court upheld, against constitutional attack, the maintenance of a centralized State computer file that contained the names and addresses of all persons who had obtained certain prescription drugs, for which there was both a lawful and an unlawful market. Recognizing that

patients have a protected interest "in avoiding disclosure of personal matters" as well as an interest in "independence in making certain kinds of important decisions," 429 U.S. at 599-600, the Supreme Court nonetheless held that "the New York program does not, on its face, pose a sufficiently grievous threat to either interest to establish a constitutional violation." *Id.* at 600. The Court noted that the invasions of privacy necessary for the public health were not "meaningfully distinguishable from a host of other unpleasant invasions of privacy that are associated with many facets of health care," explaining:

> Unquestionably, some individuals' concern for their own privacy may lead them to avoid or to postpone needed medical attention. Nevertheless, disclosures of private medical information to doctors, to hospital personnel, to insurance companies, and to public health agencies are often an essential part of modern medical practice even when the disclosure may reflect unfavorably on the character of the patient.

Id. at 602. In response to the appellants' suggestions that the information could become public through deliberate or negligent conduct in numerous ways, the Court stated that "the remote possibility that judicial supervision of the evidentiary use of particular items of stored information will provide inadequate protection against unwarranted disclosures is surely not a sufficient reason for invalidating the entire patient-identification program." *Id.* at 601-02.

Similarly, in *Danforth,* the patients attacked a record-keeping provision of Missouri's abortion statute contending, among other things, that it invaded the patient's "right to privacy in the physician-patient relationship." 428 U.S. at 57. Under the Missouri statute, abortion providers were required to fill out state forms that were to be maintained confiden-

tially and would be used only for statistical purposes. Nevertheless, the information was reportable to local, state and national public health officers. In upholding these requirements, the Court said: "Recordkeeping and reporting requirements that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible." *Id.* at 80. The Court explained that the requirements of confidentiality and the limited duration of document-maintenance (seven years) "assist[ed] and persuad[ed]" the Court to conclude that the recordkeeping requirement had no "legally significant impact or consequence on the abortion decision or on the physician-patient relationship." *Id.* at 81.

***12** Similarly, we noted in our previous opinion in this case that the recordkeeping and copying requirements were justified to ensure compliance with health care standards. *Bryant I,* 222 F.3d at 171. We added that this was particularly so in view of the regulation's requirement that all records be treated as confidential. While our conclusion in *Bryant I* was limited to holding that the recordkeeping requirement did not unduly burden the abortion decision, the observation is still relevant to this discussion on privacy insofar as it supports a conclusion that recordkeeping requirements are meaningful to the overall health and safety purposes of Regulation 61-12.

Accordingly, we conclude that South Carolina's recordkeeping requirement does not *per se* violate the Constitution. This does not, however, answer the entire question of whether the reporting requirements and the potential for publication through court proceedings renders the requirements unconstitutional, as the abortion clinics argue. South Carolina must still demonstrate that the records it requires that contain personal information will be maintained in confidence to the extent possible as it uses the records to ensure the health and safety of its citizens. *See Whalen,* 429 U.S. at 602 (noting that disclosure to public health agencies are "an

essential part of modern medical practice"); *Walls,* 895 F.2d at 192 (recognizing limits on an individual's right to privacy and requiring the government to move a compelling interest only if there will be disclosure of protected information). We conclude that South Carolina's statutes and Regulation 61-12 assure the patient's confidentiality, such that protected information will not be disclosed.

First, with respect to every facility licensed by the DHEC, the confidentiality of patient files is demanded. Section 44-7-310 of the South Carolina Code provides that the information received by the DHEC "which does not appear on the face of the license may not be disclosed publicly in a manner as to identify individuals or facilities." S.C. Code Ann. § 44-7-310. The only exception provided is for a proceeding involving licensure or an order of court. *Id.* Similarly, § 44-7-315, which authorizes the disclosure of information relating to licensed facilities, provides that "the Department may not disclose the identity of individuals present in a facility licensed by the department pursuant to this article or subject to inspection by the department." S.C. Code Ann. § 44-7-315.

The abortion statute itself, which requires that each abortion be reported to the DHEC, also provides that "the names of the patient and physician may not be reported on the form or otherwise disclosed to the state registrar." S.C. Code Ann. § 44-41-60. Finally, even in a court proceeding involving abortion licensure, the abortion statute requires that the court make an explicit ruling whether "the anonymity of any woman upon whom an abortion is performed or attempted shall be preserved from public disclosure if she does not give her consent to such a disclosure." S.C. Code Ann. § 44-41-360. In making that ruling, the court is explicitly required to apply the appropriate constitutional standard. *See id.*

***13** Consistent with these statutory mandates to preserve the privacy of patients, Regulation 61-12 explicitly requires confidentiality of patients' records. Section 402 pro-

vides that "[a]ll records shall be treated as confidential." Moreover, employees working in abortion clinics must be trained on the "confidentiality of patient information and records, and protecting patient rights." *See* DHEC Reg. 61-12, § 204(F)(3). Section 209 requires that each licensed facility have "written policies and procedures to assure the individual patient the right to dignity, *privacy,* safety, and to register complaints with the department." *Id.* § 209(A) (emphasis added).

While § 102(F) authorizes a State inspector to review records for compliance with the abortion statute and with Regulation 61-12, that authorization to inspect records does not authorize the inspector to breach the statutory and regulatory mandates to protect the patient's privacy. The Supreme Court has recognized that "[r]equiring such disclosures to representatives of the State having responsibility for the health of the community, does not automatically amount to an impermissible invasion of privacy." *Whalen,* 429 U.S. at 602. As the Court observed in *Danforth,* "recordkeeping of this kind, if not abused or overdone, can be useful to the State's interest in protecting the health of its female citizens, and may be a resource that is relevant to decisions involving medical experience and judgment." 428 U.S. at 81.

For these reasons, we conclude that the recordkeeping and information reporting mechanisms adopted by South Carolina in its statutes and in Regulation 61-12 do not require unnecessary disclosure of protected information, in violation of the privacy right identified in *Whalen,* 429 U.S. at 599-600. Even though the abortion clinics can conceive of circumstances where patients' privacy rights could be violated, either deliberately or through negligence, we cannot assume that the confidentiality measures adopted by South Carolina to prevent such violations will be administered improperly. *Whalen,* 429 U.S. at 601-02.

Accordingly, we reverse the district court's conclusion that Regulation 61-12 violates patients' privacy rights, as

identified in *Whalen,* insofar as it permits the disclosure of patient identification to the State officials administering the program. *See Whalen,* 429 U.S. at 602-03 (finding constitutional a State maintained computer file containing the *names* and addresses of patients for whom drugs had been prescribed).

VI

In sum, on the abortion clinics' constitutional challenges to Regulation 61-12 based on (1) a standardless delegation of licensing authority, (2) an alleged violation of the Establishment Clause, and (3) a claim of vagueness, we reject the abortion clinics' arguments and affirm the district court. On South Carolina's cross-appeal challenging the district court's ruling that § 102(F) of Regulation 61-12 is unconstitutional, we reverse.

***14** *AFFIRMED IN PART REVERSED IN PART.*

KING, Circuit Judge, dissenting:

We today address significant questions arising from one of the most divisive and contentious issues in our nation's history. Since *Roe v. Wade* was decided by the Supreme Court in 1973, the struggle over the existence and scope of a woman's constitutional right to choose has been a constant part of our political landscape. In recent years, state legislatures have taken an increasingly active role in regulating access to abortion; in many places, burdensome regulations have made abortions effectively unavailable, if not technically illegal. It is this type of regulation — micromanaging everything from elevator safety to countertop varnish to the location of janitors' closets — that is challenged in this case. 24 S.C. Code Ann. Regs. 61-12 (Cum. Supp. 2001) (the "Regulation").[1]

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[1] Although South Carolina claims that the Regulation treats abortion clinics similarly to other entities regulated by the State, several facts belie this assertion. First, as Judge Hamilton aptly pointed out the first time this case was appealed, "South Carolina does not require licensing of

The State of South Carolina is entitled to make a value judgment, as a matter of its public policy, to favor childbirth over abortion. *Rust v. Sullivan,* 500 U.S. 173, 192-93 (1991); *Maher v. Roe,* 432 U.S. 464, 474 (1977). In accordance with this prerogative, South Carolina has made its preference clear. For example, while a citizen of the Palmetto State may obtain a "Choose Life" automobile license plate from the authorities, he may not obtain a "Choose Choice" license plate.[2] S.C. Code Ann. § 56-3-8910 (West 2002).[3] Insofar as the legislature in South Carolina wishes to limit the choices of its female citizens, it has been largely successful. Eighty percent of the State's counties lack an abortion provider, and between 1992 and 1996, the number of such providers in the State fell from eighteen to fourteen. Stanley K. Henshaw, "Abortion Incidence and Services in the United States, 1995-1996," *Fam. Plan. Persp.,* Vol. 30, No. 6, November/December 1998.

South Carolina is not, however, entitled to adopt and pursue an anti-abortion agenda at the expense of constitutional

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physicians' offices outside of the abortion context." *Greenville Women's Clinic v. Bryant,* 222 F.3d 157, 178 (4th Cir. 2000) (Hamilton, J., dissenting). Second, the South Carolina Department of Health and Environmental Control ("DHEC"), in writing the Regulation, specifically tailored it to abortion clinics. *Id.* at 184-85. Finally, the Regulation contains some provisions, such as the clergy referral requirement discussed below, *see infra* Part II, that are found nowhere else in the South Carolina Code.

[2] I express no view on whether this policy is impacted by our recent decision in *Sons of Confederate Veterans, Inc. v. Commissioner of the Virginia Department of Motor Vehicles,* 288 F.3d 610 (4th Cir. 2002).

[3] Other South Carolina statutes demonstrate a similar hostility to a woman's constitutional right to seek an abortion. *See, e.g.,* S.C. Code Ann. § 1-1-1035 (West 2002) (prohibiting Medicaid funds from being used to fund abortions); S.C. Code Ann. § 44-41-340(A)(2) (West 2002) (requiring that women seeking abortions be provided with a brochure that includes "materials designed to inform the woman of the probable anatomical and physiological characteristics of the embryo or fetus at two-week gestational increments"); S.C. Code Ann. § 44-41-40 (West 2002) (entitling private hospitals to refuse to perform abortions).

rights. Having carefully examined the constitutional challenges made by Greenville Women's Clinic and other abortion providers (collectively, the "Plaintiffs") to aspects of the Regulation, I am inexorably led to conclude that certain of its provisions violate the Constitution. I part company with my friends in the majority in four respects:

> First, the majority improperly reverses the district court on the informational privacy issue;
>
> Second, the majority ignores the conflict between the clergy referral requirement and the Establishment Clause;
>
> Third, the majority upholds unconstitutionally vague and ambiguous provisions of the Regulation; and
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> Fourth, the majority endorses a standardless delegation of state power that contravenes the Due Process Clause.

I will discuss each of these points in turn.[4]

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[4] The majority also improperly focuses on the fact that the Plaintiffs have challenged the Regulation on its face. In *United States v. Salerno,* 481 U.S. 739 (1987), the Supreme Court articulated a "no set of circumstances" test that would, if applicable, make a facial challenge virtually impossible to win. However, the *Salerno* doctrine is an embattled one at best, and its continuing viability is the subject of intense debate. In any event, the Court has indicated that the *Salerno* standard does not apply to three of the four legal claims asserted here. *See Santa Fe Indep. Sch. Dist. v. Doe,* 530 U.S. 290, 313-14 (2000) (analyzing a facial challenge in an Establishment Clause case without applying *Salerno*); *Stenberg v. Carhart,* 530 U.S. 914, 921 (2000) (same for privacy); *Chicago v. Morales,* 527 U.S. 41, 55 (1999) (plurality) (same for vagueness). So long as plaintiffs possess standing to raise a claim, facial challenges are generally evaluated under the same standard as any other constitutional challenge, and the majority simply confuses the issues in suggesting otherwise.

I.

On the first of the Plaintiffs' four challenges to the Regulation, I would affirm the district court and hold § 102(F)(2) (the "Disclosure Provision") to be unconstitutional.[5] The Disclosure Provision concerns the State's access to private medical records,[6] and the district court properly found that South Carolina had failed to demonstrate a sufficient interest in obtaining information identifying the female patients of abortion clinics.[7] The majority incorrectly reverses the district court on this issue.

***15** The Supreme Court has identified two types of privacy rights, both rooted in the Fourteenth Amendment. The first is the right of citizens to make certain personal choices, such as those discussed by the Court in *Roe v. Wade,* 410 U.S. 113 (1973), and its progeny. The second protects "informational privacy," and it consists of a citizen's right to control the release of personal information. *Whalen v. Roe,* 429 U.S. 589, 599-600 (1977). The public disclosure of private medical records, and the personal and confidential in-

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[5] The Disclosure Provision provides, in pertinent part, that:

> Department inspectors shall have access to all ... records and reports, and shall have the authority to make photocopies of those documents required in the course of inspections or investigations.

24 S.C. Code Ann. Regs. 61-12, § 102(F)(2) (Cum. Supp. 2001).

[6] Pursuant to § 401(A)(1) of the Regulation, abortion clinics in South Carolina are required to maintain records with various identifying information, including:

> name, address, telephone number, social security number, date of birth, father's and mother's names when patient is a minor, husband's name, and name, address and telephone number of person to be notified in the event of an emergency.

24 S.C. Code Ann. Regs. 61-12, § 401(A)(1) (Cum. Supp. 2001).

[7] By definition, the Regulation only applies to clinics "in which any second trimester or five or more first trimester abortions per month are performed." 24 S.C. Code Ann. Regs. 61-12, § 101(B) (Cum. Supp. 2001). However, for ease of reference, I use the terms "clinics" or "providers," without any further elaboration, to refer to those facilities subject to the Regulation.

formation contained therein, implicates this informational privacy right.

Of course, the right to informational privacy is not absolute, and a state does not necessarily violate that right by requiring disclosure of private medical records. *Id.* at 602. To determine whether the Disclosure Provision infringes the right to informational privacy, we consider three factors. First, the information must fall within the zone of the constitutional right to privacy. *Walls v. City of Petersburg,* 895 F.2d 188, 192 (4th Cir. 1990). Second, if the information is within this zone, then "the defendant has the burden to prove that a compelling governmental interest in disclosure outweighs the individual's privacy interest." *Id.* Finally, any safeguards provided by the State against improper disclosure will serve to dilute the individual's privacy interest. Overall, the State's need for private information must be balanced against the interest of the person whose privacy is at stake. *Id.* at 192-94. As the district court properly determined, South Carolina has failed to demonstrate a sufficient need for access to patients' private identifying information, rendering its Disclosure Provision invalid. *See Greenville Women's Clinic v. Bryant,* Memorandum of Decision, CA No. 6:96-1898-20 (D.S.C. Aug. 31, 2001) (the "Memorandum of Decision").

A.

The constitutional right to privacy in pregnancy-related medical information is firmly established. Indeed, the Supreme Court has emphasized that the decision of a woman to exercise her constitutional right to choose "is an intensely private one that must be protected in a way that assures anonymity." *Thornburgh v. Am. Coll. of Obstetricians and Gynecologists,* 476 U.S. 747, 766 (1986), *overruled in part on other grounds, Planned Parenthood v. Casey,* 505 U.S. 833 (1992); *see Hodgson v. Minnesota,* 497 U.S. 417, 463 (1990) ("Few decisions are more personal and intimate, more properly private, or more basic to individual dignity and auton-

omy, than a woman's decision ... whether to end her pregnancy.") (quoting *Thornburgh,* 476 U.S. at 772); *see also Skinner v. Ry. Labor Executives' Ass'n,* 489 U.S. 602, 617 (1989) (subjecting drug testing program to scrutiny under the Fourth Amendment because it threatened to reveal private information such as pregnancy). Given the Court's recognition of the private nature of reproductive decisions, the women seeking services at abortion clinics in South Carolina unquestionably possess a constitutionally protected privacy interest in the information sought by the State under the Disclosure Provision.

B.

***16** In assessing the validity of the Disclosure Provision, we must also consider whether South Carolina has established "a compelling governmental interest in disclosure [that] outweighs the individual's privacy interest." *Walls,* 895 F.2d at 192; *see also Carey v. Population Servs. Int'l,* 431 U.S. 678, 686 (1977). In this regard, the pivotal question is whether the State can sufficiently justify its request for disclosure of constitutionally protected information.

The Supreme Court has recognized that a state has an interest in protecting maternal health, and that it may properly collect otherwise private medical information related to this purpose. *See Planned Parenthood of Cent. Mo. v. Danforth,* 428 U.S. 52, 80 (1976). However, as *Walls* informs us: the "regulation 'may be justified only by compelling state interests, and must be narrowly drawn to express only those interests.'" *Walls,* 898 F.2d at 192 (quoting *Carey,* 431 U.S. at 686).

South Carolina has failed to demonstrate that it has a compelling need to copy any patient identifying information. The only justification offered by the State is that such information is needed in order to investigate complaints against abortion clinics. However, the State has failed to demonstrate a need to contact patients in such situations. In fact, complaints involving compliance with issues such as struc-

tural building requirements and staff qualifications could be fully investigated by the State without contacting the female patients. And on issues involving patient care, the affected patients would most likely consent to the disclosure of their identity.

In limited situations, the State might have a valid need to obtain a patient's identity in order to investigate anonymous complaints or to seek corroborating evidence. However, South Carolina's interest in obtaining patients' identifying information in those limited situations does not support the disclosure requirement in the Regulation, which gives the State access to information identifying *every* patient of *every* abortion clinic in the State. Such a disclosure requirement is vastly overbroad: in the apparent expectation that, someday, some of the information might be useful, it tramples the privacy interest of every woman who seeks an abortion at a South Carolina clinic.

In short, South Carolina has failed to demonstrate a compelling need for access to information identifying every patient of the abortion clinics in the State. As the district court properly recognized, the goals of the Disclosure Provision would be adequately served if the State is provided with access to *redacted* records. Memorandum of Decision, at 8-9. And in those limited instances where redacted records might be insufficient, the State has failed to narrowly tailor the Disclosure Provision to serve its interest in disclosure.

C.

In assessing whether the Disclosure Provision contravenes the right to informational privacy, we must also consider the probability of the unauthorized disclosure of the information collected by the State. *Walls,* 895 F.2d at 194; *see also Watson v. Lowcountry Red Cross,* 974 F.2d 482, 487-88 (4th Cir. 1992). Any safeguards designed by the State to prevent such improper disclosure serve to weaken a woman's privacy interest and reduce the need to prohibit South Caro-

lina from collecting the information in the first place. *Walls,* 895 F.2d at 194.

***17** In this case, the State has failed to show that it will protect the private medical information of female patients. To begin with, the statutes relied on by South Carolina do not erect an absolute bar to public disclosure of such information. *See* S.C. Code Ann. § 44-7-310 (West 2002);[8] S.C. Code Ann. § 44-7-315 (West 2002).[9] To the contrary, those statutes contain gaping holes in the protections they afford against public disclosure. For example, § 44-7-310 authorizes the public disclosure of identifying information during licensure proceedings. And § 44-7-315 *requires,* upon written request, the public disclosure of information obtained through inspection.

While § 44-7-315 serves to prohibit South Carolina from "disclos[ing] the identity of individuals present in a facility," it fails to explain what "present in a facility" is intended to mean. Under one interpretation, it might only protect the identity of persons present in the facility at the time records are released. Under another plausible interpretation, it could cover only those persons typically present in the facility — namely the permanent staff. And among other possible in-

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[8] Section 310, regarding "Certain information not to be disclosed publicly," states:

> Information received by the Office of Health Licensing ... may not be disclosed publicly in a manner as to identify individuals or facilities *except* in a proceeding involving the licensure or certification of need of the facility or licensing proceedings against an employee of the facility or as ordered by a court of competent jurisdiction.

S.C. Code Ann. § 44-7-310 (West 2002) (emphasis added).

[9] Section 315, titled "Disclosure of information regarding facility or home," reads, in pertinent part:

> Information received by the Division of Health Licensing ... *must be disclosed* publicly upon written request to the department.... The department *may not disclose the identity of individuals present in a facility* licensed by the department....

S.C. Code Ann. § 44-7-315 (West 2002) (emphasis added).

terpretations, it could mean that the identity of every person ever present in the facility may not be disclosed, which would include investigators and other State officials. In short, this ambiguous statutory language does not sufficiently ensure the confidentiality of the female patients of South Carolina abortion clinics.

Second, despite the State's assurances of confidentiality, private medical information has been leaked to the public. Although George Moore, the Director of Outpatient and Home Care in the Department of Health and Environmental Control ("DHEC"), testified that "strict confidentiality is maintained as it always is, records are secured in the office, and individual records are not released under Freedom of Information Act requests," South Carolina has failed to follow this directive. In point of fact, the evidence shows that abortion protesters distributed a flyer containing a photocopy of a medical record obtained from DHEC concerning a fifteen-year-old girl's pregnancy termination. Furthermore, physicians testified that similar types of confidential information collected by the State have been made available to the public.

D.

It is of significance, in assessing the validity of the Disclosure Provision, that the recordkeeping requirements established by South Carolina differ markedly from the types of data collection systems other courts have approved. For example, in *Whalen v. Roe,* 429 U.S. 589 (1977), the Supreme Court concluded that New York was constitutionally permitted to obtain and record, in a centralized computer file, the names and addresses of all persons who obtained, pursuant to a doctor's prescription, certain controlled substances for which there were both lawful and unlawful markets. *Id.* at 591-94. In that situation, New York provided elaborate security against the improper disclosure of private medical information, including storing the records in a receiving room surrounded by an alarmed and locked wire fence, and requiring destruction of the records after five years. *Id.* at

593-94. Further, the public disclosure of patients' identities was expressly prohibited by both a statute and an administrative regulation. *Id.* at 594-95.

***18** The situation in this case differs markedly from *Whalen* in at least three respects. First, as discussed above, *see supra* Part I.C., South Carolina's Disclosure Provision does not sufficiently ensure the confidentiality of private medical information. Second, the medical records of abortion patients differ in substance from the records collected in *Whalen.* In *Whalen,* the information compiled on drug use provided potentially incriminating evidence about the patients themselves, not just about the medical doctors who wrote the prescriptions. *Id.* at 592. Here, the private medical information sought by South Carolina is not for the purpose of investigating the female patients of abortion clinics. Rather, the State claims that such information will facilitate its investigations of the clinics providing abortion services.[10]

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[10] Where this Court has permitted a government entity to collect and maintain private information, the government interest has consistently related to the person whose privacy is at stake. *See Walls,* 895 F.2d at 192-93 (upholding data collection of police department applicants because of state interest in obtaining personal information of employees); *Hodge v. Jones,* 31 F.3d 157, 166 (4th Cir. 1994) (upholding data collection of reports of child abuse to aid future investigations of parents). The majority has unjustifiably extended these earlier decisions by now allowing South Carolina to collect patient information in order to investigate clinics.

In the only situation where the need to obtain private information related to a third party, the scope of the privacy invasion was narrowly tailored to the need for disclosure. In *Watson,* the plaintiff, who asserted a claim against a Red Cross donation center, was allowed to obtain discovery from an anonymous blood donor. 974 F.2d at 484. Thus, the interest in obtaining the information related to the Red Cross, while it was the donor whose privacy was compromised. However, in that case, only one donor's identity was at stake, and it was revealed only to the court. The trial court allowed the plaintiff to submit questions to counsel for the anonymous donor, but the identities of the donor and the donor's counsel were known only to the court. *Id.* at 484, 487. In contrast, the South Carolina Regulation provides the State with access to *every* patient record without any judicial supervision on how the information is used.

Finally, the plaintiffs in *Whalen* claimed to fear the disclosure of their medical records because of the stigma attached to the use of controlled substances. *Id.* at 595 n. 16. In this case, women seeking abortions in South Carolina have a great deal more to fear than stigma. The protests designed to harass and intimidate women entering abortion clinics, and the violence inflicted on abortion providers, provide women with ample reason to fear for their physical safety. *See Thornburgh,* 476 U.S. at 767 n. 12.

For these reasons, the identifying information contained in medical records of women seeking services at abortion clinics in South Carolina must be kept confidential. The majority, in my view, is entirely unable to justify South Carolina's broad access to unredacted records, and it has not shown that the purported safeguards ameliorate privacy concerns. In sum, the Disclosure Provision violates the constitutionally protected right of informational privacy, and the majority is incorrect to conclude otherwise.

II.

I also disagree with the majority on the constitutionality of § 307 of the Regulation (the "Consultation Provision").[11] The Plaintiffs maintain that the Consultation Provision unconstitutionally compels South Carolina abortion clinics to form professional affiliations with members of the clergy and entangles the State in religious matters.[12] The majority, on

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[11] The Consultation Provision of the Regulation, found in § 307, requires that:

> Arrangements shall be made for consultation or referral services in the specialties of obstetrics/gynecology, anesthesiology, surgery, psychiatry, psychology, clinical pathology and pathology, *clergy,* and social services, as well as any other indicated field, to be available as needed.

24 S.C. Code Ann. Regs. 61-12, § 307 (Cum. Supp. 2001) (emphasis added).

[12] Plaintiffs also contend that the Consultation Provision improperly gives religious leaders veto authority over the issuance of abortion licenses. Because I would find that the Provision violates the Establish-

the other hand, views the Plaintiffs' concerns as "grounded on a substantial misreading of § 307, imputing obligations and relationships that are not prescribed by the regulation." *Ante* at 10. Specifically, the majority believes that "[t]hese arrangements might amount to no more than a list of clergy and other specialists or a readily accessible telephone book to consult as required by the needs of a particular patient," and that no arrangement for religious counseling need be made until a patient requests the referral. *Ante* at 10-11.

In concluding that the Consultation Provision complies with the Establishment Clause, the majority interprets the clergy referral requirement in a plainly implausible way. Under a reasonable interpretation of the Consultation Provision, abortion providers in South Carolina must establish professional affiliations with members of the clergy in order to ensure that religious consultation and referral services will be available to their female patients. And to enforce this Provision, the State inevitably must establish and enforce religious criteria. Because the Establishment Clause[13] precludes South Carolina from becoming entangled with religion in this way, the Consultation Provision is unconstitutional.

A.

***19** In South Carolina, duly promulgated state regulations, like statutes, are to "receive practical, reasonable and fair interpretation consonant with the purpose, design and policy of lawmakers." *Whiteside v. Cherokee County*

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ment Clause in excessively entangling the State with religious counseling, I would not reach the issue of whether the Consultation Provision might also give religious leaders too much authority over government functions. *See generally Larkin v. Grendel's Den, Inc.*, 459 U.S. 116 (1982). I do, however, address a similar contention in dealing with the Regulation's improper delegation of state authority. *See infra* Part IV.

[13] The Establishment Clause provides that "Congress shall make no law respecting an establishment of religion." U.S. CONST. amend. 1. It has been incorporated against the states through the Fourteenth Amendment. *Zelman v. Simmons-Harris*, 534 U.S. ----, 122 S. Ct. 2460, 2465 (2002); *Everson v. Bd. of Educ. of Ewing Township*, 330 U.S. 1, 15-16 (1947).

Sch. Dist. No. 1, 428 S.E.2d 886, 888 (S.C. 1993). Viewed in this way, the express terms of the Consultation Provision cannot support the majority's strained interpretation; the Provision unequivocally requires clinics to establish prearrangements for consultation services with members of the clergy. Although the services must be "available as needed," the arrangements plainly must be made before a clinic can obtain a license. Moreover, the "arrangement" requirement of the Consultation Provision indicates that abortion providers must do more than merely make a telephone book available to their female patients. Indeed, for a female patient to have access to specialists in the fields specified in the Consultation Provision, such as anesthesiology or surgery, a telephone book would not be particularly helpful. And the majority gives no reason why the mandated "arrangements" with members of the clergy should be treated differently.

Further, the majority's interpretation of the Consultation Provision inexplicably ignores the explicit intent of the South Carolina official who wrote the Regulation. According to Mr. Moore, the Director of Outpatient and Home Care in the Division of Licensing of DHEC, and the state official who drafted the Regulation, clinics must make *prearrangements* for consultation.[14] In fact, Mr. Moore testified that prior arrangements are required with "maybe two or three different denominations just to be on call." Although "[i]t probably

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[14] In general, an agency's interpretation of its own regulation deserves considerable deference. *See Brown v. S.C. Dep't of Health & Envtl. Control,* 560 S.E.2d 410, 415 (S.C. 2002). Although a position taken in litigation (which is one way Mr. Moore's view could be characterized) may be treated differently, a policy statement should be given deference where it reflects the considered and reasoned judgment of the agency, rather than a post hoc rationalization of an enforcement decision. *See Monongahela Power Co. v. Reilly,* 980 F.2d 272, 279 (4th Cir. 1993). Mr. Moore's testimony therefore is entitled to consideration in assessing what the Consultation Provision requires. Further, because South Carolina inspectors have broad discretion to determine what might violate the Consultation Provision, abortion providers would be well advised to heed DHEC's warning on how the law will be enforced.

wouldn't be a Catholic priest," Mr. Moore opined that they "would just have to have Protestant and whatever else." Given the plain terms of the Consultation Provision and the unequivocal statements of its drafter, abortion providers in South Carolina must, in order to comply with the Provision, do more than merely provide their patients with a telephone book. *Ante* at 10.

B.

It is with this interpretation of the clergy referral requirement in mind that I turn to an assessment of the constitutionality of the Consultation Provision. In order to determine whether a regulation violates the Establishment Clause, we must apply the three-prong test that the Supreme Court articulated in *Lemon v. Kurtzman,* 403 U.S. 602 (1971). First, the regulation must have a secular purpose. Second, the primary effect of the regulation must neither advance nor inhibit religion. And third, the regulation must not foster an excessive government entanglement with religion. *Id.* at 612-13. As explained below, the Consultation Provision clearly violates *Lemon's* third prong, and it probably contravenes the second prong as well.

1.

The first prong of the *Lemon* test presents a fairly low hurdle for the State. *Brown v. Gilmore,* 258 F.3d 265, 276 (4th Cir.), *cert. denied,* 122 S. Ct. 465 (2001). Here, the Consultation Provision appears to have a secular purpose. The State promulgated it for the ostensible purpose of protecting maternal health and to ensure that women seeking abortion services have access to experts in a range of specialty fields. The first prong of *Lemon* contemplates an inquiry into the subjective intentions of the government. *See Wallace v. Jaffree,* 472 U.S. 38, 56 (1985) ("[I]t is appropriate to ask 'whether government's actual purpose is to endorse or disapprove of religion.'") (quoting *Lynch v. Donnelly,* 465 U.S. 668, 690 (O'Connor, J., concurring)). Without more

evidence of a religious purpose, the Consultation Provision survives the first prong of the *Lemon* test.

2.

***20** By contrast, the Consultation Provision in all likelihood fails *Lemon's* second prong. This prong's "primary effect" test requires an objective assessment, rather than a subjective one, and it measures whether the principal effect of government action "is to suggest government preference for a particular religious view or for religion in general." *Barghout v. Bureau of Kosher Meat & Food Control,* 66 F.3d 1337, 1345 (4th Cir. 1995). Here, the Consultation Provision compels physicians providing abortion services to establish affiliations with religious institutions. This mandatory affiliation seems to convey the message that the State endorses the beliefs of the religious counselors. Further, the clergy referral requirement appears to promote the religious mission of those institutions given referral arrangements.[15] Under our Constitution, however, the government is not permitted to sponsor the indoctrination of religious beliefs in this manner.

More disturbingly, South Carolina has indicated it will play favorites among religions in enforcing the Consultation

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[15] Unlike those situations where courts have permitted religious groups to provide state-sponsored counseling services, the message of the clergy in this case is purely religious. Further, the counseling services here *must* be provided by pervasively sectarian organizations. South Carolina is not merely allowing religious groups to participate on an equal basis in grant programs; it has facilitated religious indoctrination. In *Bowen v. Kendrick,* 487 U.S. 589 (1988), the Supreme Court held that religious groups could receive funds from the government in order to counsel teenagers regarding adolescent sexual relations. However, the counseling services were not inherently religious, the grant program directed that the money should be spent for secular purposes, and the groups providing counseling services were not pervasively sectarian. *See id.* at 604-05 ("The services to be provided under the AFLA are not religious in character, nor has there been any suggestion that religious institutions or organizations with religious ties are uniquely well qualified to carry out those services.") (internal citation omitted); *see also id.* at 610-12.

Provision.[16] The interpretation given to this Provision by DHEC's Division of Licensing unquestionably violates the hallmark of the Establishment Clause, which is that the government must be neutral with respect to different religious beliefs. According to Mr. Moore, referral arrangements with members of the clergy must include at least one Protestant minister, and they need not include a Catholic priest. This governmental preference for certain religious beliefs violates what Judge Luttig has characterized as "the most fundamental tenet of the Establishment Clause [which] is that the imprimatur of the state shall not directly or indirectly be placed upon one religious faith over another." *Id.* at 1346 (Luttig, J., concurring). Given these defects, the Consultation Provision almost certainly contravenes the second prong of the *Lemon* test.

3.

In any event, the Consultation Provision surely fails the third prong of the *Lemon* test, because it excessively entangles the State with religion. Under *Lemon's* final prong, the Court requires that we analyze "the character and purposes of the institutions that are benefited, the nature of the aid that the State provides, and the resulting relationship between the government and religious authority." *Lemon,* 403 U.S. at 615. In this case, the benefited institutions are quintessentially religious. Unlike the religious groups that have elsewhere been allowed to participate in government programs, the institutions that receive the benefit of referral arrange-

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[16] If the Consultation Provision is enforced in a manner where certain religions are actually favored, as Mr. Moore suggests, it should be enjoined without applying the *Lemon* analysis. *Larson v. Valente,* 456 U.S. 228, 252 (1982) ("[T]he *Lemon v. Kurtzman* 'tests' are intended to apply to laws affording a uniform benefit to *all* religions, and not to provisions ... that discriminate *among* religions."); *see also County of Allegheny v. ACLU Greater Pittsburgh Chapter,* 492 U.S. 573, 604 (1989) ("Whatever else the Establishment Clause may mean ... it certainly means at the very least that government may not demonstrate a preference for one particular sect or creed.").

ments under the Consultation Provision are pervasively sectarian. By virtue of the Consultation Provision, churches in South Carolina have been given additional opportunities to proselytize; female patients of abortion providers will now be referred to a preacher at the direction of the State. Such a referral requirement is unprecedented, and it should be recognized as unconstitutional.

***21** Further, the State's enforcement of the Consultation Provision will inevitably entangle the State in religious counseling. DHEC inspectors and bureaucrats must determine not only whether the mandated clergy referral arrangements have been made, but also whether the arrangements with members of the clergy satisfy criteria that are necessarily religious. To enforce the Consultation Provision, the State must inquire into who qualifies as an appropriate member of the "clergy," and it must decide whether the referral arrangements are sufficient to meet the religious needs and preferences of female patients. In requiring DHEC inspectors to determine whether abortion providers have complied with these religious requirements, the Consultation Provision excessively entangles the State in religious indoctrination. As such, it violates the Establishment Clause, and it should be invalidated.

III.

While I agree with the majority that most of the challenged aspects of the Regulation are sufficiently clear to withstand a constitutional vagueness analysis,[17] I see two of those provisions as unconstitutionally vague. First, the inspectors for South Carolina have unbridled discretion to decide whether an abortion provider in that State has somehow deviated from an amorphous "best practices" requirement, which is found both in Chapter 10 and § 103 of the Regulation (the "Best Practices Provisions"). *See* 24 S.C. Code

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[17] In particular, I agree that §§ 102(J), 102(L), 201(B), 204, 205(C)(1), 301, 306-308, 501(A), 602(A), 604, 606, and 807 of the Regulation are not unconstitutionally vague.

Ann. Regs. 61-12, Chapter 10 (Cum. Supp. 2001); 24 S.C. Code Ann. Regs. 61-12, § 103(C) (Cum. Supp. 2001).[18] Second, under a particularly incomprehensible section, abortion clinics in South Carolina must arrange for local hospital admitting privileges for either some or all of their staffs. However, exactly which staff members are required to possess such privileges is inherently ambiguous because of an unfortunately placed "and/or" connector found in § 305 of the Regulation (the "And/Or Provision"). *See* 24 S.C. Code Ann. Regs. 61-12, § 305(A) (Cum. Supp. 2001).[19] The majority unjustifiably and incorrectly ignores the fundamental vagueness of these Provisions.

The Due Process guarantee of the Fourteenth Amendment prohibits state statutes and regulations that are "so vague that men of common intelligence must necessarily guess at [their] meaning and differ as to [their] application." *Smith v. Goguen,* 415 U.S. 566, 572 n. 8 (1974) (quoting *Connally v. Gen. Constr. Co.,* 269 U.S. 385, 391 (1926)). Further, such statutes and regulations may not be so vague

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[18] Chapter 10 of the Regulation provides: "Conditions arising that have not been addressed in these regulations shall be managed in accordance with the best practices as interpreted by the Department." 24 S.C. Code Ann. Regs. 61-12, Chapter 10 (Cum. Supp. 2001). Section 103(C) similarly states that "Class III violations are those that are not classified as Class I or II in these regulations or those that are against the best practices as interpreted by the Department." 24 S.C. Code Ann. Regs. 61-12, § 103(C) (Cum. Supp. 2001). The majority concentrates on Chapter 10 in discussing the "best practices" requirement. *Ante* at 16. However, because Chapter 10 and § 103(C) contain the same "best practices" language, I refer to them collectively as the "Best Practices Provisions."

[19] Section 305(A) of the Regulation reads:

> All staff *and/or* consulting physicians shall have admitting privileges at one or more local hospitals that have appropriate obstetrical/gynecological services or shall have in place documented arrangements approved by the Department for the transfer of emergency cases when hospitalization becomes necessary.

24 S.C. Code Ann. Regs. 61-12, § 305(A) (Cum. Supp. 2001) (emphasis added).

that they invite arbitrary and discriminatory enforcement. *Kolendar v. Lawson,* 461 U.S. 352, 357 (1983); *see also Papachristou v. City of Jacksonville,* 405 U.S. 156, 162 (1972) (invalidating an ordinance on vagueness grounds partially because it encouraged "arbitrary and erratic arrests and convictions"); *see generally City of Chicago v. Morales,* 527 U.S. 41, 56 (1999) (plurality); *Grayned v. City of Rockford,* 408 U.S. 104, 108-09 (1972).

A.

***22** In order to be consistent with the requirements of due process, statutes and regulations with criminal sanctions must achieve a higher level of clarity than those which provide for civil penalties only. *Village of Hoffman Estates v. Flipside, Hoffman Estates, Inc.,* 455 U.S. 489, 498-99 (1982) ("The Court has also expressed greater tolerance of enactments with civil rather than criminal penalties because the consequences of imprecision are qualitatively less severe."). While the majority acknowledges this principle, it inexplicably and incorrectly assumes that violations of the Regulation carry civil penalties only. *Ante* at 4, 16. On the contrary, a violation of the general licensing article of the South Carolina Code, which applies specifically to health care facilities providing abortion services to women in South Carolina, constitutes a misdemeanor criminal offense. S.C. Code Ann. § 44-7-340 (West 2002). In order to be constitutional, the Regulation's licensing scheme must therefore be analyzed under the standard of clarity applicable to criminal offenses.

Further, even if criminal penalties were not implicated, the Regulation threatens the exercise of constitutionally protected rights. For this reason alone, it must achieve a heightened level of precision. *Colautti v. Franklin,* 439 U.S. 379, 391, 394 (1979) (noting that regulations that threaten abortion rights are held to a higher level of clarity). Indeed, the constitutionally protected right to seek an abortion has been treated with such hostility that abortion providers are uniquely susceptible to being targeted by arbitrary and dis-

criminatory enforcement. *Women's Med. Ctr. of Northwest Houston v. Bell,* 248 F.3d 411, 422 (5th Cir. 2001) ("Especially in the context of abortion, a constitutionally protected right that has been a traditional target of hostility, standardless laws and regulations ... open the door to potentially arbitrary and discriminatory enforcement."). Given the fact that the South Carolina licensing scheme threatens criminal penalties, and in light of the additional fact that constitutionally protected rights are at stake, the provisions of the Regulation must be especially clear as to what is required and what is prohibited.

B.

1.

The majority candidly concedes that the "best practices" requirement makes Chapter 10 the "most unclear provision in Regulation 61-12." *Ante* at 16. Under the Best Practices Provisions, a South Carolina abortion provider must comply with "best practices as interpreted by the Department." 24 S.C. Code Ann. Regs. 61-12, Chapter 10 (Cum. Supp. 2001); 24 S.C. Code Ann. Regs. 61-12, § 103(C) (Cum. Supp. 2001). Despite recognizing that the Best Practices Provisions lack clarity, the majority fails to subject them to a vagueness analysis. The proper answers to two questions dispose of the issue: Would a person of reasonable intelligence understand what is required by the Best Practices Provisions? The answer is "No." Is the language of these Provisions so standardless that it enables arbitrary and discriminatory enforcement? The answer is "Yes."

***23** The majority seems to rely, inappropriately, on a reading of the Regulation "in its entirety" in deciding to uphold the Best Practices Provisions. *Ante* at 15. The Supreme Court, however, has recently demonstrated that overbreadth and vagueness analyses are to be conducted on a provision-by-provision basis. *See Ashcroft v. Free Speech Coalition,* 534 U.S. ---, 122 S. Ct. 1389, 1405-06 (2002) (analyzing

different provisions of the Child Pornography Prevention Act separately and concluding that only certain subsections violated the First Amendment). Standing alone, the Best Practices Provisions contained in Chapter 10 and § 103 of the Regulation offer no guidance on the scope of their coverage, and they are therefore unconstitutionally vague.

2.

The And/Or Provision found in § 305(A) of the Regulation, as the majority acknowledges, is also "inherently ambiguous." *Ante* at 12. This Provision requires that "[a]ll staff *and/or* consulting physicians shall have admitting privileges at one or more local hospitals." 24 S.C. Code Ann. Regs. 61-12, § 305(A) (Cum. Supp. 2001) (emphasis added). Because of the "and/or" connector, abortion providers in South Carolina, who are subject to criminal sanctions if they violate the Regulation, lack sufficient notice as to what is required of them. *Cf. United States v. Bush,* 70 F.3d 557, 562 (10th Cir. 1995) (discussing the inherent vagueness of an indictment with an "and/or" connector). On the one hand, the And/Or Provision might require all staff physicians and all consulting physicians to have admitting privileges at local hospitals. On the other hand, it might require either all staff physicians or all consulting physicians to have admitting privileges. To add to the confusion, the word "staff" in this Provision could be functioning either as a noun or as an adjective. If it is a noun, it is possible to read the And/Or Provision to require that the receptionist, at every abortion clinic in the State, possess admitting privileges.

3.

In sum, neither the Best Practices Provisions nor the And/Or Provision set forth a sufficiently ascertainable standard of conduct to provide the abortion providers in South Carolina with proper notice of their scope. Therefore, we should hold each of these Provisions to be unconstitutionally vague.

IV.

Finally, the majority errs in ruling that the Regulation's delegation of decisionmaking authority over abortion licensing complies with due process requirements. Several parts of the Regulation give private parties authority over the licensing of abortion providers in South Carolina. These provisions include: § 205(C)(2),[20] § 305(A),[21] and § 309(B)[22] (collectively, the "Hospital Privilege Provisions"), as well as the Consultation Provision. Because these Provisions give private parties unguided power to refuse to affiliate with abortion clinics, they should be recognized as unconstitutional delegations of government licensing authority.

***24** Because the licensing scheme spelled out in the Regulation threatens to deprive abortion providers in South Carolina of a protected property interest and to burden the liberty interest of women seeking abortions, it must comport with due process. The Due Process Clause requires licensing decisions to be based upon established standards, rather than upon the whim or caprice of the licensor. *Yick Wo v. Hopkins,* 118 U.S. 356, 370 (1886); *see also GE Co. v. N.Y. State Dep't of Labor,* 936 F.2d 1448, 1454-55 (2nd Cir. 1991); *Hornsby v. Allen,* 326 F.2d 605, 608 (5th Cir. 1964). And if

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20 Section 205(C)(2) of the Regulation provides:

> The facility shall enter into a signed written agreement with at least one physician board-certified in obstetrics and gynecology (if not one on staff) who has admitting privileges at one or more local hospitals with OB/GYN services to ensure his/her availability to the staff and patients during all operating hours.

24 S.C. Code Ann. Regs. 61-12, § 205(C)(2) (Cum. Supp. 2001).

21 I have previously designated § 305(A) of the Regulation as the "And/Or Provision." *See supra* Part III. It is also one of the Hospital Privilege Provisions implicated in the improper delegation challenge to the Regulation's hospital admitting privilege requirements.

22 Section 309(B) of the Regulation provides: "Physicians shall have admitting privileges at one or more local hospitals that have appropriate obstetrical/gynecological services." 24 S.C. Code Ann. Regs. 61-12, § 309(B) (Cum. Supp. 2001).

a state decides to delegate part of its licensing authority to a third party, that authority must be exercised in a manner that is consistent with due process requirements. *Hallmark Clinic v. N.C. Dep't of Human Res.*, 380 F. Supp. 1153, 1158-59 (E.D.N.C. 1974) (three-judge panel), *aff'd in part on other grounds*, 519 F.2d 1315 (4th Cir. 1975).

The Plaintiffs maintain that several provisions of the Regulation constitute an improper delegation, without sufficient standards, of the State's licensing authority. Specifically, the Plaintiffs challenge the mandate of the Hospital Privilege Provisions that physicians (and/or others) possess admitting privileges at local hospitals, and they challenge the Consultation Provision's referral arrangement requirement. The Plaintiffs maintain that these provisions grant hospitals and medical specialists, as well as members of the clergy, an effective "veto power" over the licensing of abortion providers. The State, on the other hand, does not contend that the Regulation provides any standards or guidelines for when, or under what circumstances, third parties may refuse to affiliate with abortion providers. It relies, instead, on the irrelevant fact that such providers have not yet had difficulty obtaining licenses.

In rejecting the Plaintiffs' delegation challenges, it is striking that the majority fails to address two contrary decisions directly on point. Indeed, a three-judge district court in this Circuit concluded that a state may not constitutionally delegate to hospitals the unbridled control over abortion licensing by conditioning a license on hospital admitting privileges. In *Hallmark Clinic*, Judge J. Braxton Craven, Jr., then a distinguished member of this Court from North Carolina, addressed the very question we face today, and the majority takes issue with his reasoning without mentioning his considered opinion.[23] In that case, Hallmark Clinic chal-

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[23] The *Hallmark Clinic* panel was convened pursuant to a statute, since repealed, that required a special three-judge court to hear and decide claims seeking to enjoin the enforcement of a state statute on constitu-

lenged a North Carolina licensing scheme that required abortion providers to have transfer agreements with local hospitals. 380 F. Supp. at 1156. Because the challenged North Carolina regulation did not limit the discretion of hospitals to decide whether to grant such privileges, the court held that the regulation constituted an unconstitutional delegation. As Judge Craven concluded, "the state cannot confer upon a private institution the exercise of arbitrary and capricious power." *Id.* at 1159. If a state requires that physicians have admitting privileges in hospitals in order to obtain licenses to perform abortions, "it must establish and enforce standards for admission to hospital staff privileges." *Id.* Here, South Carolina, like North Carolina in the 1970s, has "given hospitals the arbitrary power to veto the performance of abortions for any reason or no reason at all. The state cannot grant hospitals power it does not have itself." *Id.* at 1158-59.

***25** In *Birth Control Centers, Inc. v. Reizen,* 508 F. Supp. 1366 (E.D. Mich. 1981), *aff'd in part and vacated in part on other grounds,* 743 F.2d 352 (6th Cir. 1984), a district court in Michigan invalidated a regulation similar to the North Carolina licensing scheme at issue in *Hallmark Clinic.* There, Michigan had promulgated a regulation requiring abortion providers to obtain transfer agreements with local hospitals before they could obtain a license. *Id.* at 1369. Relying on the *Hallmark Clinic* decision, the court struck down the Michigan regulation as an impermissible delegation of state power. *See id.* at 1374 (holding that hospital privilege requirements "violate due process concepts because they delegate a licensing function to private entities without standards to guide their discretion"); *see also GE Co. v. N.Y. State Dep't of Labor,* 936 F.2d at 1455 ("[A] legislative body may not constitutionally delegate to private parties the power

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tional grounds. *See* 28 U.S.C. § 2281 (repealed 1976). While *Hallmark Clinic* may not constitute binding authority in our Circuit, Judge Craven's well-reasoned opinion, in the absence of other controlling precedent, should be considered persuasive authority and accorded great weight.

to determine the nature of rights to property in which other individuals have a property interest, without supplying standards to guide the private parties' discretion.").

Because the Hospital Privilege Provisions of the Regulation delegate the unfettered power to control the licensing of abortion providers, they violate the Due Process Clause. *See Danforth,* 428 U.S. at 74 ("[T]he State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy, regardless of the reason for withholding consent."). In addition to other constitutional infirmities, the Hospital Privilege Provisions and the Consultation Provision (for the same reasons that apply to the Hospital Privilege Provisions) constitute standardless delegations of state power. As such, they violate the Due Process Clause and should be invalidated.

V.

In sum, the majority has misapprehended the underlying facts and misapplied the applicable law in upholding the Regulation in its entirety. Under an appropriate construction of the Regulation and an application of controlling legal principles, several of its provisions are unconstitutional. In particular, the Disclosure Provision violates the right to informational privacy; the Consultation Provision contravenes the Establishment Clause (as well as the Due Process Clause in improperly delegating state licensing authority); the And/Or Provision and the Best Practices Provisions are unconstitutionally vague; and the Hospital Privilege Provisions violate due process by unconstitutionally delegating state licensing authority.

Because the majority refuses to recognize these constitutional infirmities, I respectfully dissent.

2002 WL 31928629 (4th Cir. (S.C.))

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

Greenville Women's Clinic, Charleston Women's Clinic, Inc., and William Lynn, M.D., on behalf of themselves and their patients seeking abortions,	) CA No. 6:96-1898-20
Plaintiffs,	) MEMORANDUM OF DECISION
vs.	
Douglas E. Bryant, in his official capacity as Commissioner of South Carolina Department of Health and Environmental Control, Governor of the State of South Carolina, and Charles M. Condon, in his official capacity as Attorney General of the State of South Carolina,	
Defendants.	

This matter is before the court on the briefs of the parties. The plaintiffs challenge the constitutionality of South Carolina Code Annotated Regulation 61-12 ("Regulation 61-12"). The court now declares its findings of fact and conclusions of law in accordance with Rule 52 of the Federal Rules of Civil Procedure. Should a finding of fact constitute a conclusion of law, or vice versa, the court adopts it as such and directs that it be treated accordingly.

I. FINDINGS OF FACT

1. The Greenville Women's Clinic ("GWC") is a medical practice in Greenville owned and operated by Drs. Buffkin and Campbell. (Stip. Facts ¶ 2.)

3. Dr. Lynn owns and operates a medical practice in Greenville called the Palmetto State Medical Clinic ("PSMC"). (Stip. Facts ¶ 3.)

4. Drs. Buffkin, Campbell, and Lynn are all licensed to practice medicine in South Carolina. (Stip. Facts ¶ 1.)

5. GWC and PSMC provide a range of gynecological services, including first-trimester, suction curettage abortions. (Stip. Facts ¶ 4.)

6. GWC also provides first-trimester medical abortions. (Stip. Facts ¶ 5.)

7. Both the GWC and Dr. Lynn perform over five abortions each month and well over sixty abortions per year. (Stip. Facts ¶ 6.)

8. Prior to the court's July 9, 2001, injunction, all abortion clinics in the state were licensed. (Stip. Facts ¶ 7.)

9. Drs. Buffkin and Campbell of the GWC have admitting privileges at Greenville-area hospitals. (Stip. Facts ¶ 8.)

10. Although Dr. Lynn does not have admitting privileges at a Greenville-area hospital, he does have a written transfer agreement with a local doctor who does have admitting privileges. Dr. Lynn also has admitting privileges at a Beaufort-area hospital. (Stip. Facts ¶ 9, 10.)

11. On July 27,1996, the plaintiffs filed suit seeking declaratory judgment that Regulation 61-12 was facially unconstitutional. (Compl.) Specifically, the complaint alleged that Regulation 61-12 was unconstitutional because it: (1) denied the plaintiffs equal protection of the laws; (2) deprived the plaintiffs of their right to privacy; (3) was void for vagueness; (4) violated the plaintiffs' right to due process by delegating veto power over facility licensing to third parties; (5) violated the Establishment Clause; and (6) intruded on patients' rights to confidentiality in their medical records. After a six-day bench trial, United States District Judge William B. Traxler, Jr., held that Regulation 61-12 was unconstitutional based on the plaintiffs' first two grounds. Judge Traxler did not reach the four remaining claims.

12. On August 15, 2000, the United States Court of Appeals for the Fourth Circuit reversed the district court's ruling. See Greenville Women's Clinic v. Bryant, 222 F.3d 157, 175 (4th Cir. 2000).

13. The plaintiffs subsequently requested a hearing *en banc* which was denied. On February 26, 2001, the United States Supreme Court denied certiorari. See Greenville Women's Clinic v. Bryant, 121 S. Ct. 1188 (2001).

14. Following the Supreme Court's denial of certiorari, the plaintiffs requested and the court granted a 120-day preliminary injunction to allow the plaintiffs to come into compliance with Regulation 61-12. In addition, the parties briefed the issue of whether there were any remaining claims. On June 26, 2001, the court held that because the Fourth Circuit had failed to remand the case to the district court the case had ended. See Greenville Women's Clinic v. Bryant, No, 6:96-1989 (D.S.C. June 26, 2001).

15. The plaintiffs appealed this ruling to the Fourth Circuit and the case was remanded to the district court to determine issues preserved but not decided by earlier opinions. See Greenville Women's Clinic v, Bryant, No. 01-1856 (4th Cir. July 5, 2001). On July 9, 2001, the court granted the plaintiffs a preliminary injunction pending the outcome of the remaining claims.

II. CONCLUSIONS OF LAW

The court has jurisdiction based on the presence of a federal question pursuant to 28 U.S.C. § 1331. Venue in this judicial district is appropriate based on 28 U.S.C. § 1391(b). The plaintiffs make a facial challenge to Regulation 61-12 on four grounds, alleging that the regulation is unconstitutional because it (1) is void for vagueness; (2) violates the plaintiffs' right to due process by delegating veto power over facility licensing to third parties; (3) violates the Establishment Clause; and (4) intrudes on patients' rights to confidentiality in their medical records.

A. Vagueness

The plaintiffs assert that Regulation 61-12 is unconstitutionally vague. "A statute can be impermissibly vague for either of two independent reasons. First, if it fails to provide people of ordinary intelligence a reasonable opportunity to understand what conduct it prohibits. Second, if it authorizes or even encourages arbitrary and discriminatory enforcement." Hill v. Colorado, 530 U.S. 703, 732 (2000). "[S]peculation about possible vagueness in hypothetical situations not before the Court will not support a facial attack on a statute when it is surely valid 'in the vast majority of its intended applications.'" Id. at 733 (quoting United States v. Raines, 362 U.S. 17, 23 (1960)). A statute can never be held to mathematical certainty. See id. A statute is not vague because "difficulty is found in determining whether certain marginal offenses fall within [its] language." United States v. National Dairy Prods. Cor., 372 U.S. 29, 32 (1963). The plaintiffs cite a litany of phrases which are allegedly unconstitutionally vague. After review of the sections and taking the Regulation 61-12 as a whole, the court finds that people of ordinary intelligence would be able to understand what the regulation requires, and that the statute does not encourage arbitrary and discriminatory enforcement. In fact, it appears that the majority of the Regulation 61-12 is identical to the American College of Obstetricians and Gynecologists' ("ACOG") standards for obstetricians and gynecologists. See Bryant, 222 F.3d at 167 ("Regulation 61-12 largely tracks [the ACOG] medical standards and guidelines.") Therefore, the court finds that the plaintiffs' constitutional challenge to Regulation 61-12 on this ground must fail.

B. Unlawful Delegation of Veto Power

The plaintiffs allege that Regulation 61-12 should be stricken because it allows for the unconstitutional delegation of veto power to a third party. Specifically, the plaintiffs assert that members of the public, i.e. local clergy, doctors, and hospitals, have the ability to prevent a clinic from becoming

licensed.[1] The plaintiffs rely on Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) for the proposition that the government cannot give a third party absolute veto power over abortion decisions. See 428 U.S. at 74. In Danforth, the Court struck down a statute which required a spouse's consent or parental consent for a minor before a woman could obtain an abortion. As support for its conclusion, the Court cited Eisenstadt v. Baird, 405 U.S. 438 (1972) which established that "[i]f the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." 405 U.S. at 453 (emphasis in original). While Regulation 61-12 may affect a woman's selection of an abortion facility, it does nothing to impede an individual woman's right to choose to have an abortion.

The constitutional challenge put forth by the plaintiffs regarding the veto argument has nothing to do with a woman's constitutional right to have an abortion. Instead, the plaintiffs are concerned with the potential that they will be deprived of a property interest without being afforded due process under the fourteenth amendment. The plaintiffs, however, have failed to demonstrate that physicians would not be afforded due process in obtaining hospital privileges. Therefore, the plaintiffs' challenge to Regulation 61-12 on this ground must fail. See generally Women's Health Center of West County, Inc. v. Webster, 871 F.2d 1377 (8th Cir. 1989) (statute requiring physician performing abortions to have attending privileges at a hospital held constitutional);

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[1] Regulation 61-12 requires that a clinic have attending privileges or a transfer agreement with a local hospital and have an arrangement for consultation and referral services in the specialities of obstetrics/gynecology, anesthesiology, surgery, psychiatry, psychology, clinical pathology and pathology, clergy, and social services, as well as any other indicated field, to be available as needed. See S.C. Code Ann. Reg. 61-12 §§ 205(C)(2), 305(A), & 307.

but see Birth Control Ctrs., Inc. v. Reizen, 508 F. Supp. 1366 (E.D. Mich. 1981), aff'd in part, vacated in part, 743 F.2d 352 (6th Cir. 1984) (invalidating requirement that clinic have transfer agreement with hospital); Hallmark Clinic v. North Carolina Dep't of Human Res., 380 F. Supp. 1153 (E.D.N.C. 1974) (holding that requirement that clinics have written agreements with hospitals for patient access was unconstitutional).

C. Establishment Clause

The plaintiffs assert that Regulation 61-12 violates the Establishment Clause of the United States Constitution. To pass constitutional muster with regard to the Establishment Clause, (1) the statute must "have a secular purpose"; (2) its "principal or primary effect must be one that neither advances nor inhibits religion"; and (3) "the statute must not foster 'an excessive government entanglement with religion.'" Lemon v. Kurtzman, 403 U.S. 602, 612-13 (1971) (quoting Walz v. Tax Comm'n, 397 U.S. 664, 674 (1970)). "The endorsement test does not preclude government from acknowledging religion or from taking religion into account in making law and policy." Wallace v. Jaffree, 472 U.S. 38, 69 (1985) (O'Connor, J., concurring). The plaintiffs assert that Regulation 61-12 violates the Establishment Clause in two ways. First, because the statute requires that the clinic have clergy available for counseling and second, because the regulation delegates veto power to a religious entity. The court finds these arguments unpersuasive.

First, as to the requirement that the clinic have clergy available for counseling, the plaintiffs have not asserted nor does the court find that Regulation 61-12 has a non-secular purpose. The purpose of the statute is to safeguard the health of women seeking abortions. See Greenville Women's Clinic v. Bryant, 222 F.3d 157, 168 (4th Cir. 2000). Nor is the primary effect of this portion of the regulation to advance or inhibit religion. The regulation does not require a patient to undergo religious counseling. It simply requires that such

counseling be available if needed. The court does not see how the availability of religious counseling advances or inhibits religion. Finally, the statute does not foster an "excessive" government entanglement with religion. See Lemon, 403 U.S. at 612-13. While the requirement itself is religious in nature, it does not require that the functions of government and religion become intertwined. Because the regulation only requires third parties, not state officials, to provide for the availability of religious counseling, it is a far cry from an excessive entanglement.

As to the assertion that the regulation impermissibly delegates veto power to a religious entity thereby violating the Establishment Clause, the plaintiffs rely on Larkin v. Grendel's Den, Inc., 459 U.S. 116 (1932) and Board of Education of Kiryas Joel Village School District v. Grumet, 512 US. 687 (1994). In Larkin, a Massachusetts statute gave governing bodies of schools and churches the power to prevent the issuance of a liquor license for premises within five hundred feet of a church or school. The Supreme Court held that this statute violated the Establishment Clause. In Kiryas Joel, a state school district carved out a special school district for a village which consisted exclusively of practitioners of a strict form of Judaism. The Supreme Court held that this district improperly allocated political power to a religious group. These cases are distinguishable from the case at bar.

First, Regulation 61-12 does not vest the power to prevent the issuance of a license to any one person or entity. In Larkin, a single school or church could prevent the issuance of a liquor license. In this case, there would be multiple opportunities for a clinic to find clergy members who are willing to be available for counseling. As to Kiryas Joel, the religious group was essentially vested with enormous authority to run a public school in accordance with religious beliefs. That is quite different from requiring a medical clinic to have religious counselors available. Also, as stated above, the regulation has a secular purpose, does not promote or inhibit

religion, and does not excessively entangle the government with religion. See Lemon, 402 U.S. at 612-13. For these reasons, the court finds that Regulation 61-12 does not offend the Establishment Clause.

D. Informational Privacy

Last, the plaintiffs assert that Regulation 61-12 violates their right to privacy. Specifically, the plaintiffs assert that patients' names and medical records are subject to government review. "The constitutional right to privacy extends to two types of interests; 'one is the individual interest in avoiding disclosure of personal matters, and another is the interest in independence in making certain kinds of important decisions.'" Walls v. City of Petersburg , 895 F.2d 188, 192 (4th Cir. 1990) (quoting Whalen v. Roe, 429 U.S. 589, 599-600 (1977)). "Personal, private information in which an individual has a reasonable expectation of confidentiality is protected by one's constitutional right to privacy." Id. "The right to privacy, however, is not absolute." Id. "If the information is protected by a person's right to privacy, then the defendant has the burden to prove that a compelling governmental interest in disclosure outweighs the individual's privacy interest." Id.

The defendants do not dispute that an individual has a reasonable expectation of confidentiality in the medical records at issue, and it appears that the plaintiffs object only to the availability of records which contain identifying information. (Pl.'s Mem. Of Law on Remaining Claims at 9.) While the Fourth Circuit has recognized that the "inspections ensure compliance with healthcare standards," Bryant, 222 F.3d at 171, the defendants have provided the court with no compelling interest in the disclosure of identifying information. The defendants argue that there are multiple safeguards in place to protect the confidentiality of the information contained in the medical records. This is irrelevant, however, if the defendants cannot articulate a compelling interest in viewing the information. Therefore, the court finds that sec-

tion 102(F)(2) of Regulation 61-12, which requires that "department inspectors shall have access to all properties and areas, objects, records, and reports, and shall have the authority to make photocopies of those documents required in the course of inspection or investigations," to be unconstitutional insofar as it requires access to identifying information.[2] See Thornburgh v. American College of Obstetrics and Gynecology, 476 U.S. 747, 766 (1985) ("The decision to terminate a pregnancy is an intensely private one that must be protected in a way that assures anonymity").

E. Severability

Because the court determines that a portion of Regulation 61-12 is unconstitutional, it must consider whether that portion of Regulation 61-12 is severable from the remaining regulation. "A statute may be constitutional and valid in part and unconstitutional and invalid in part." Thayer v. South Carolina Tax Comm'n, 413 S.E.2d 810, 814 (1992). "The test for severability is whether the constitutional portion of the statute remains complete in itself, wholly independent of that which is rejected, and is of such a character as that it may fairly be presumed that the Legislature would have passed it independent of that which is in conflict with the Constitution." Id. at 814-15 (internal quotations and citations omitted). Even in the absence of a severability clause, it is clear that declaring the portion of the regulation which allows the defendants to inspect records which include identifying information is easily severable, leaving the remaining regulation complete.

Therefore, the court finds that the unconstitutional portion of Regulation 61-12 is severable.

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[2] This constitutional problem can be cured by the plaintiffs redacting the documents to remove such information.

III. ORDER

In light of the above findings of fact and conclusions of law, it is

ORDERED that plaintiffs' constitutional challenge to Regulation 61-12 fails except for the provision which allows for the inspection of documents which contain identifying information. The statute is only unconstitutional to the degree that the documents are not redacted to remove such information. It is further

ORDERED that the preliminary injunction now in place is hereby dissolved.

IT IS SO ORDERED.

/s/
Henry M. Herlong, Jr.
United States District Judge

Greenville, South Carolina
August 31, 2001

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

FILED
November 8, 2002

No. 01-2090
CA-96-1898-6-20

GREENVILLE WOMEN'S CLINIC; WILLIAM LYNN, MD, on behalf of themselves and their patients seeking abortions

Plaintiffs – Appellants

and

CHARLESTON WOMEN'S MEDICAL CLINIC, INCORPORATED

Plaintiff

v.

COMMISSIONER, SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL; GOVERNOR OF SOUTH CAROLINA; CHARLES MOLONY CONDON, in his official capacity as Attorney General of the State of South Carolina

Defendants – Appellees

No. 01-2235
CA-96-1898-6-20

GREENVILLE WOMEN'S CLINIC; WILLIAM LYNN, MD, on behalf of themselves and their patients seeking abortions

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and

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Plaintiff

v.

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Defendants – Appellants

On Petition for Rehearing and Rehearing En Banc

Appellants' petition for rehearing and rehearing en banc was submitted to the Court. A majority of judges having voted in a requested poll of the Court to grant rehearing en banc,

IT IS ORDERED that rehearing en banc is granted.

IT IS FURTHER ORDERED that this case shall be calendared for argument at the January 21 - 24, 2003 session of Court. Within ten days of the date of this order, twenty (20) additional copies of appellant's brief, twenty (20) additional copies of appellee's brief, twenty (20) additional copies of

the appellant's reply brief, if any, twenty (20) additional copies of amicus curiae brief, if any, and twenty (20) additional copies of any previously filed supplemental authorities pursuant to Rule 28(j), FRAP, shall be filed. Counsel for amicus parties, if any, must file a motion for leave to participate in oral argument should they wish to be heard at argument.

Appellants will file twenty (20) additional copies of the joint appendix.

For the Court,

/s/ Patricia S. Connor
CLERK

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This court's order dated November 8, 2002, was improvidently entered and is now vacated.

On the request for a poll on the motion for rehearing en banc, Judge Wilkins, Michael, Motz, King, and Gregory voted to rehear the case. Chief Judge Wilkinson and Judges Widener, Niemeyer, and Luttig voted against rehearing the case, and Judges Williams and Traxler were disqualified from voting. Because a majority of the active judges did not vote in favor of the motion, it is denied.

Entered at the direction of Judge Niemeyer for the Court.

For the Court,
/s/ Patricia S. Connor
CLERK

South Carolina Department of Health and Environmental Control

Regulation Number 61-12

Standards for Licensing

Abortion Clinics

[*logo*]

Promulgated by the Board of Health and Environmental Control

Administered by the Division of Health Licensing

Published in the State Register,
Volume 20, Issue 6, June 28, 1996

This is a courtesy copy of Regulation 61-12

The official document is on record in the State Register and the Code or Regulations of S.C., 1976, as amended.

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South Carolina
Department of Health and Environmental Control

REGULATION 61-12.
STANDARDS FOR LICENSING ABORTION CLINICS

Statutory Authority: Sections 44-41-10, et seq., and 44-7-110, et seq., of the Code of Laws of South Carolina, 1976, as amended.

CHAPTER 1 - DEFINITIONS AND REQUIREMENTS FOR LICENSURE

SECTION 101. Definitions

For the purposes of these regulations, the following definitions apply:

A. Abortion. The use of an instrument, medicine, drug, or other substance or device with intent to terminate the pregnancy of a woman, known to be pregnant, for reasons other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

B. Abortion Clinic. Any facility, other than a hospital as defined in Section 101.J, in which any second trimester or five or more first trimester abortions per month are performed.

C. Allied Health Professional. A person other than a physician who possesses specialized training and skill acquired by completing certain courses of study or intensive job-related training and, where applicable, has been duly licensed or registered by appropriate licensing or certification agencies. All allied health professionals must be supervised by a physician.

D. Conception. The fecundation of the ovum by the spermatozoa.

E. Consent. A signed and witnessed voluntary agreement to the performance of an abortion.

F. Department. The South Carolina Department of Health and Environmental Control.

G. Emancipated Minor. A minor who is or has been married or has by court order been freed from the care, custody, and control of her parents.

H. Fetal Death. Death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

I. Fire Safety Authority. The State Fire Marshal, or his designee, who performs facility fire and safety inspections.

J. Hospital. An institution licensed for hospital operation by the Department in accordance with the provisions of Article 3, Chapter 7, Title 44, of the S.C. Code of Laws, 1976, as amended, and that has also been certified by the Department to be a suitable facility for the performance of abortion.

K. In Loco Parentis. Any person over the age of 18 who has placed him/herself in the position of a lawful par-

ent by assuming obligations that are incidental to the parental relationship and has so served for a period of 60 days.

L. Licensee. The person, partnership, corporation, association, organization, or professional entity on whom rests the ultimate responsibility and authority for the conduct of the abortion clinic.

M. Medical Emergency. That condition which, on the basis of the physician's good faith judgment, so complicates a pregnancy as to necessitate an immediate abortion to avert the risk of her death or for which a delay will create serious risk of substantial and irreversible impairment of major bodily functions.

N. Minor. A female under the age of 17.

O. Physician. A person licensed to practice medicine in this State.

P. Pregnancy. The condition of a woman carrying a fetus or embryo within her body.

Q. Probable Gestational Age of the Embryo or Fetus. What, in the judgment of the attending physician, based upon the attending physician's examination and the woman's medical history, is with reasonable probability, the gestational age of the embryo or fetus at the time the abortion is planned to be performed. This estimate must be guided by recommendations found in The American College of Obstetricians and Gynecologists Standards for Obstetric-Gynecologic Services, i.e., calculated from the first day of the last menstrual period.

R. Products of Conception. Fetal and embryonic tissues resulting from implantation in the uterus.

S. Trimester. A 12-week period of pregnancy.

1. First. The first 12 weeks of pregnancy commencing with conception rather than computed on the basis of the menstrual cycle.

2. Second. That portion of a pregnancy following the 12th week and extending through the 24th week of gestation.

3. Third. That portion of pregnancy beginning with the 25th week of gestation.

4. All other references in this regulation to gestational age will refer to that calculated from the first day of the last menstrual period as used in The American College of Obstetricians and Gynecologists Standards for Obstetric-Gynecologic Services. The following is furnished to provide clarification of gestational age:

Calculation	Weeks of Gestational Age								
Conception	8	10	12	14	16	18	20	22	24
LMP	10	12	14	16	18	20	22	24	26

T. Viability. That stage of human development when the fetus is potentially able to live outside of the mother's womb with or without the aid of artificial life support systems. (Section 44-41-10(l) of the SC Code of Laws further states that "for the purposes of this chapter, a legal presumption is hereby created that viability occurs no sooner than the twenty-fourth week of pregnancy." The "twenty-fourth week," as

stated in the S.C Code, is based on computation from date of conception, i.e., the twenty-sixth week from the first day of the last menstrual period.)

SECTION 102. License Requirements

A. License. It shall be unlawful to operate an abortion clinic within South Carolina without possessing a valid license issued annually by the Department. (I)

B. Issuance of License. A license is issued pursuant to the provisions of Section 44-41-10 et seq., of the South Carolina Code of Laws of 1976, as amended, and these standards, and shall be posted in a conspicuous place in a public area within the facility. The issuance of a license does not guarantee adequacy of individual care, treatment, personal safety, fire safety or the well-being of any occupant of a facility. A license is not assignable or transferable and is subject to revocation by the Department for failure to comply with the laws and regulations of the State of South Carolina.

C. Effective Date and Term of License. A license shall be effective for a 12-month period following the date of issue and shall expire one year following such date; however, a facility that has not been inspected during that year may continue to operate under its existing license until an inspection has occurred.

D. Separate Licenses. Separate licenses are required for facilities not maintained on the same premises.

E. Licensing Fees. The initial and annual license fee shall be $500.00 for each licensed facility. Such fee

shall be made payable to the Department. Fees are non-refundable.

F. Inspections. Each facility shall be inspected prior to initial licensure and at least annually thereafter by authorized representatives of the Department.

1. All licensed facilities are subject to inspection at any time.

2. Department inspectors shall have access to all properties and areas, objects, records and reports, and shall have the authority to make photocopies of those documents required in the course of inspections or investigations. (II)

G. Initial License. A new facility, or one that has not been continuously licensed under these or prior standards, shall not provide care to patients until it has been issued an initial license. When it is determined that the facility is in compliance with the requirements of these standards, and a properly completed application and licensing fee have been received by the Department, a license shall be issued. Chapter 9 of this regulation sets forth the prerequisites for initial licensure. (I)

H. License Renewal. Applicants for an annual license renewal shall file an application with the Department, pay a license fee, and undergo a licensing inspection.

I. Noncompliance. When noncompliance(s) with the licensing standards exists, the applicant or licensee shall be notified by the Department of the violation(s) and required to provide information as to how and

when each violation will be corrected and how future occurrences may be prevented.

J. Facility Name. No proposed abortion clinic shall be named, nor may any existing abortion clinic have its name changed to, the same or similar name as any other abortion clinic licensed in the State. If it is part of a "chain operation" it shall then have the geographic area in which it is located as part of its name.

K. Change of License. A facility shall request issuance of an amended license by application to the Department prior to any of the following circumstances:

1. Change of ownership by purchase or lease;

2. Change of facility's name or address.

L. Exceptions to Licensing Standards. The Department may make exception(s) to these standards where it is determined that the health and welfare of the community require the services of the facility and that the exception(s), as granted, will have no significant adverse impact on the health, safety, or welfare of the facility's patients.

SECTION 103. Penalties

When it determines that a facility is in violation of any statutory provision, rule or regulation relating to the operation or maintenance of such facility, the Department, upon proper notice, may deny, suspend, or revoke licenses, or assess a monetary penalty. Under such conditions, the following shall apply:

A. Class I violations are those that the Department determines to present an imminent danger to the health, safety, or welfare of the patients of the facility or a substantial probability that death or serious physical harm could result therefrom. A physical condition or one or more practices, means, methods or operations in use in a facility may constitute such a violation. The condition or practice constituting a Class I violation shall be abated or eliminated immediately unless a fixed period of time, as stipulated by the Department, is required for correction. Each day such violation shall exist after expiration of said time shall be considered a subsequent violation.

B. Class II violations are those, other than Class I violations, that the Department determines to have a direct or immediate relationship to the health, safety or well-being of the facility's patients. The citation of a Class II violation shall specify the time within which the violation is required to be corrected. Each day such violation shall exist after expiration of said time shall be considered a subsequent violation.

C. Class III violations are those that are not classified as Class I or II in these regulations or those that are against the best practices as interpreted by the Department. The citation of a Class III violation shall specify the time within which the violation is required to be corrected. Each day such violation shall exist after expiration of said time shall be considered a subsequent violation.

D. Class I and II violations are indicated by notation after each applicable section, i.e., (I) or (II). Violations of sections that are not annotated in that manner denote Class III violations.

E. In arriving at a decision to penalize a facility, the Department will consider the following factors: specific conditions and their impact or potential impact on health, safety or well-being; efforts by the facility to correct; overall conditions; history of compliance; any other pertinent conditions that may be applicable to current statutes and regulations.

F. When a decision is made to assess monetary penalties, the following schedule will be used as a guide to determine the dollar amount:

Frequency of violation of standard within a 24-month period: MONETARY PENALTY RANGES

Frequency	Class I	Class II	Class III
1st	$ 200 – 1000	$ 100 – 500	$ 0
2nd	500 – 2000	200 – 1000	100 – 500
3rd	1000 – 5000	500 – 2000	200 – 1000
4th	5000	1000 – 5000	500 – 2000
5th	5000	5000	1000 – 5000
6th	5000	5000	5000

G. Any facility that is dissatisfied with Department decisions may request a hearing pursuant to the Administrative Procedures Act.

CHAPTER 2 - ADMINISTRATION AND MANAGEMENT

SECTION 201. Licensee (II)

A. The licensee of each facility has the ultimate responsibility for the overall operation of the facility. Every facility shall be organized, equipped, staffed and administered to provide adequate care for each person admitted.

B. Policies and procedures for operation of the facility shall be formulated and reviewed annually by the licensee of the facility. They shall include but not be limited to:

1. Purpose of the facility, to include scope and quality of services;

2. Ensuring compliance with all relevant federal, state, and local laws that govern operations of the facility;

3. Personnel policies and procedures, to include in-service training requirements;

4. The person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the licensee for holding such individual responsible;

5. Provision for annual review and evaluation of the facility's policies, procedures, management and operation;

6. Provision for a facility-wide quality improvement program to evaluate patient care. The program shall be ongoing, have statistical summaries, and have a written plan of implementation.

7. Patient rights and grievance procedures;

8. Functional safety and maintenance policies and procedures;

9. Incident reporting;

10. Consent must be informed, shall be obtained prior to the procedure, and shall include evidence of an explanation by a physician or allied health professional of the services offered and potential risks. Documentation of the informed consent must be filed in the patient's record.

SECTION 202. Administrator (II)

An administrator shall be selected by the licensee and shall have the ability and authority to manage and administer the facility. Any change in the position of the administrator shall be reported immediately by the licensee to the Department in writing. An individual shall be appointed in writing to act in the absence of the administrator.

SECTION 203. Administrative Records

The following administrative documents and references shall be on file in the facility:

A. Current policies and procedures concerning the operation of the facility; (II)

B. Current memorandums of agreement and credentialing documentation.

C. A current copy of these regulations;

D. Annual elevator safety inspections, if applicable;

E. Annual heating, ventilation, and air conditioning inspection report.

SECTION 204. Personnel (II)

Each facility shall have a staff that is adequately trained and capable of providing appropriate service and supervision to the patients.

A. The licensee shall obtain written applications for employment from all employees. The licensee shall obtain and verify information on the application as to education, training, experience, appropriate licensure, if applicable, and health and personal background of each employee.

B. Prior to performing job duties, all employees, to include volunteers who have direct patient contact within the clinic, shall have tuberculin skin testing conducted unless a previously positive reaction is documented in millimeters. The intradermal (Mantoux) method, using five tuberculin units of stabilized purified protein derivative (PPD) is to be used. For employees/volunteers who have no documentation of a negative PPD result during the preceding 12 months, then the two-step procedure (one PPD test with negative result followed one to three weeks later by another PPD test) is required to establish a reliable baseline. If employees/volunteers have complete

documentation of a negative PPD during the preceding 12 months (may be a single PPD or a two-step PPD), then a single PPD is acceptable to establish the baseline for current employment.

1. Persons with negative tuberculin skin tests who have direct contact with patients shall have an annual tuberculin skin test.

2. There is no need to perform an initial or routine chest X-ray on employees or volunteers with negative tuberculin tests who are asymptomatic.

3. Personnel with a positive reaction to the skin test shall have no patient contact until certified non-contagious by a physician.

4. Employees and volunteers with reactions of 10mm and over to the pre-employment tuberculin test, those new employees/volunteers who have previously-documented positive reactions, those with newly-converted skin tests and those with symptoms suggestive of TB (e.g., cough, weight loss, night sweats, fever, etc.), shall be given a chest X-ray to determine whether TB disease is present. If TB disease is diagnosed, appropriate treatment shall be given and contacts examined.

5. Personnel who are known or suspected to have TB shall be required to be evaluated by a physician and will not be allowed to return to work until they have been certified non-contagious by the physician.

6. Preventive treatment of personnel with new positive reactions is essential, and shall be considered

for all infected employees/volunteers who have patient contact, unless specifically contraindicated. Routine annual chest X-rays of persons with positive reactions do not prevent TB and therefore are not a substitute for preventive treatment nor are required.

a. Employees and volunteers who complete treatment, either for disease or infection, may be exempt from further routine chest radiographic screening unless they have symptoms of TB.

b. Positive reactors who are unable or unwilling to take preventive treatment need not receive an annual chest X-ray. These individuals must be informed of their lifelong risk of developing and transmitting TB to individuals in the institution and in the community. They shall be informed of symptoms which suggest the onset of TB, and the procedure to follow should such symptoms develop.

7. Post-exposure skin tests should be provided for tuberculin negative employees/volunteers within 12 weeks after termination of contact for any suspected exposure to a documented case of pulmonary TB.

8. A person shall be designated in writing at each facility to coordinate TB screening of personnel and any other TB control activities.

C. All professional and allied health professional staff members shall be currently certified with American Red Cross or American Heart Association CPR and

capable of recognizing symptoms of distress. A professional or allied health professional staff member who is legally qualified to perform advanced cardiac life support must be present while patients are undergoing abortion procedures/ recovery in the facility. (I)

D. No employee or volunteer of the facility, while afflicted with any infected wounds, boils, sores, or an acute respiratory infection, or any other contagious disease or illness, shall work in any capacity in which there is a likelihood of such person transmitting disease to other individuals.

E. Each facility shall have and execute a written orientation program to familiarize each new staff member with the facility and its policies and procedures, to include, as a minimum, fire safety and other safety measures, medical emergencies, and infection control.

F. Inservice training programs shall be planned and provided for all employees and volunteers to insure and maintain their understanding of their duties and responsibilities. Records shall be maintained to reflect program content and individual attendance. The following training shall be provided at least annually:

1. Infection control, to include as a minimum, universal precautions against blood-borne diseases, general sanitation, personal hygiene such as handwashing, use of masks and gloves, and instruction to staff if there is a likelihood of transmitting a disease to patients or other staff members;

2. Fire protection, to include evacuating patients, proper use of fire extinguishers, and procedures for reporting fires:

3. Confidentiality of patient information and records, and protecting patient rights;

4. Licensing regulations.

G. Job Descriptions.

1. Written job descriptions that adequately describe the duties of every position shall be maintained.

2. Each job description shall include: position title, authority, specific responsibilities and minimum qualifications.

3. Job descriptions shall be reviewed at least annually, kept current and given to each employee and volunteer when assigned to the position and when revised.

H. A personnel file shall be maintained for each employee and for each volunteer. The records shall be completely and accurately documented, readily available, and systematically organized to facilitate the compilation and retrieval of information. The file shall contain a current job description that reflects the individual's responsibilities and work assignments, and documentation of the person's orientation, in-service education, appropriate licensure, if applicable, and TB skin testing.

SECTION 205. Clinical Staff (II)

A. Physicians, nurses, and allied health professionals shall constitute the clinical staff.

B. The clinical staff shall meet at least quarterly to review and analyze their clinical experiences; minutes shall be maintained of such meetings.

C. Physicians. (I)

1. Abortions shall be performed only by physicians who are licensed to practice medicine in this State and who are properly qualified by training and experience to perform pregnancy termination procedures.

2. The facility shall enter into a signed written agreement with at least one physician board-certified in obstetrics and gynecology (if not one on staff) who has admitting privileges at one or more local hospitals with OB/GYN services to ensure his/her availability to the staff and patients during all operating hours.

3. A physician must remain on the premises until all patients are stable, and are ready for discharge. A physician must sign the discharge order and be readily accessible and available until the last patient has been discharged.

D. Nursing.

1. Nursing care shall be under the supervision of a registered nurse currently licensed in this State.

2. A registered nurse shall be on duty to provide or supervise all nursing care of patients in preparation, during the termination procedure, the recovery period and until discharge by the attending physician.

3. Licensed practical nurses, working under appropriate supervision and direction of a registered nurse, may be employed as components of the nursing staff.

E. Allied health professionals, working under appropriate direction and supervision, may be employed to work only within areas where their competency has been established.

F. If ultrasonography is conducted in the clinic, the procedure shall be conducted by a physician or by an ultrasound technician who shall have documented evidence of completion of a training course in ultrasonography.

SECTION 206. Consent of the Patient (I)

A physician shall not perform an abortion without first obtaining a signed and dated consent of the pregnant woman pursuant to the provisions of Section 44-41-30 of the SC Code of Laws, 1976, as amended.

SECTION 207. Abortion Performed Upon Minors (I)

No person may perform an abortion upon a minor unless consent is obtained pursuant to the provisions of Section 44-41-31 of the SC Code of Laws, 1976, as amended.

SECTION 208. Dissemination of Information (I)

Clinics must comply with the Woman's Right to Know Act, Section 44-41-310 et seq., of the SC Code of Laws, 1976, as amended, and maintain an adequate supply of current printed material from the Department which has not been altered in content.

SECTION 209. Patients' Rights (II)

A. The facility shall have written policies and procedures to assure the individual patient the right to dignity, privacy, safety, and to register complaints with the Department. These patients' rights shall be approved by the licensee.

B. Each facility shall display in a conspicuous place a copy of the patients' rights. In addition, a copy signed by the patient shall be included in the medical record.

CHAPTER 3 - PATIENT CARE

SECTION 301. Policies and Procedures (II)

Abortion clinics shall not serve patients whose needs exceed the resources and/or capabilities of the clinic. The facility shall formulate and adhere to written patient care policies and procedures designed to ensure professional and safe care for patients, to include but not limited to:

A. Admission criteria;

B. Physician and nurse responsibilities for the services offered;

C. Specific details regarding the pre-operative procedures performed, to include:

1. History and physical examination, to include verification of pregnancy, estimation of gestational age, identification of any preexisting conditions or complications;

2. Special examinations, lab procedures, and/or consultations required, to include ultrasonography required when gestational age is clinically estimated to be equal to or more than 14 weeks from the first day of the last menstrual period as established by the physician's performance of a bimanual physical examination. Policies and procedures should also indicate that ultrasound is recommended when gestational age is equal to or more than 12 weeks from the first day of the last menstrual period as established by the performance of a bimanual physical examination or if the physical examination and clinical evidence is inconclusive as to the gestational age.

D. The actual abortion procedure, to include the use of:

1. IV's;

2. Fluids;

3. Analgesia/anesthesia. General anesthesia shall be administered only by a certified registered nurse anesthetist, anesthesiologist, or dentist anesthetist or physician anesthetist.

4. Tissue examination/disposal.

E. Post-procedure care/recovery room procedures to include emergency care;

F. Provisions for the education of patient, family and others, as appropriate in pre and post-procedure care;

G. Plans for follow-up of patient after discharge from the facility, to include arrangements for post-operative visit, and specific instructions in case of emergency;

H. Management and appropriate referral of high-risk conditions;

I. Transfer of patients who, during the course of pregnancy termination are determined to need care beyond that of the facility;

J. Infection control and sanitation procedures to include duties and responsibilities of the infection control committee that shall include the development and implementation of specific patient care and administrative policies aimed at investigating, controlling and preventing infections in the facility;

K. Registration of fetal death or death certificates, when applicable.

SECTION 302. Limitation of Services Offered by Abortion Clinics (I)

A. Abortions performed in abortion clinics shall be performed only on patients who are within 18 weeks from the first day of their last menstrual period. Those beyond 18 weeks shall be performed in a hospital. A licensed ambulatory surgical facility that is also licensed as an abortion clinic may perform abor-

tions on patients who are up to 26 weeks after the first day of their last menstrual period.

B. Clinics performing abortions beyond 14 weeks from the first day of the last menstrual period must meet the requirements of Section 309.

SECTION 303. Pharmaceutical Services (II)

Pharmaceutical services shall be provided in accordance with accepted professional practice and federal, state and local statutes and regulations.

A. Emergency Drugs:

1. Emergency Kit or Emergency Drugs. Each facility shall maintain an emergency kit or stock supply of drugs and medicines for the use of the physician in treating the emergency needs of patients. This kit or medicine shall be stored in such a manner as to prohibit its access by unauthorized personnel. A listing of contents by drawer or shelf shall be placed on the cabinet or emergency cart to allow quick retrieval. Contents shall correspond with the inventory list. Drugs and equipment must be available within the facility to treat, as a minimum, the following conditions: (I)

a. Cardiac arrest;

b. Seizure;

c. Asthmatic attack;

d. Allergic reaction;

e. Narcotic toxicity;

f. Hypovolemic shock;

g. Vasovagal shock.

2. Drug Reference Sources. Each facility shall maintain reference sources for identifying and describing drugs and medicines.

B. Administering Drugs and Medicines. Drugs and medicines shall not be administered to individual patients or to anyone within or outside the facility except by those authorized by law under orders of a physician duly licensed to prescribe drugs. Such orders shall be in writing and signed personally by the physician who prescribes the drug or medicine.

C. Medicine Storage. Medicines and drugs maintained in the facility for daily administration shall not be expired and shall be properly stored and safeguarded in enclosures of sufficient size that are not accessible to unauthorized persons. Refrigerators used for storage of medications shall maintain an appropriate temperature as determined by the requirements established on the label of medications. A thermometer accurate to ±3 degrees Fahrenheit shall be maintained in these refrigerators. Only authorized personnel shall have access to storage enclosures. Controlled substances and ethyl alcohol, if stocked, shall be stored under double locks and in accordance with applicable state and federal laws.

D. Medicine Preparation Area. Medicines and drugs shall be prepared for administration in an area that contains a counter and a sink. This area shall be lo-

cated in such a manner as to prevent contamination of medicines being prepared for administration.

E. Controlled Substances Registration.

1. If a stock of controlled drugs is to be maintained at the facility, a physician on the clinic staff shall obtain an individual practitioner South Carolina Controlled Substances Registration and a Drug Enforcement Administration (DEA) Registration as registrant for the facility. This physician shall be responsible for the proper safeguarding and handling of controlled substances within the facility, and shall be certain that all possible control measures are observed and that any suspected diversion or mishandling of controlled substances is reported immediately to the Bureau of Drug Control of the Department.

2. With a written power of attorney, this physician may grant permission to any other physician who possesses an individual practitioner South Carolina Controlled Substances Registration and a DEA Registration to administer, order for administration, or dispense any controlled substances maintained by the facility.

F. Records. Records shall be kept of all stock supplies of controlled substances giving an accounting of all items received and/or administered.

G. Poisonous Substances. All poisonous substances must be plainly labeled and kept in a cabinet or closet separate from medicines and drugs to be prepared for administration. (I)

SECTION 304. Laboratory Services (II)

A. Laboratory services shall be provided on site or through arrangement with a laboratory certified to provide the required procedures under the Clinical Laboratory Improvement Amendments of 1988 (CLIA-88).

1. Facilities for collecting specimens shall be available on site.

2. If laboratory services are provided on site they shall be directed by a person who qualifies as a director under CLIA-88 and shall be performed in compliance with CLIA-88 standards.

B. Prior to the procedure, laboratory tests shall include a recognized urine pregnancy test unless the physician identifies fetal heart beats or fetal movements on physical examination. If positive, the following additional tests are required:

1. Urinalysis including albumin and glucose examination;

2. Hematocrit or hemoglobin;

3. Determination of Rh factor (including the Du variant when the patient is Rh negative); Rh (D) immune globulin (human) shall be administered, prior to discharge, to patients who are determined to be Rh negative.

C. Other laboratory tests to be administered:

1. Testing for Chlamydia and gonorrhea;

2. Syphilis serology shall be offered;

3. A Papanicolaou procedure shall be offered;

4. Referral for chest X-ray, if indicated;

5. Other tests as deemed appropriate by the physician.

D. Aspirated tissues shall be examined to verify that villi or fetal parts are present; if villi or fetal parts cannot be identified with certainty, the tissue specimen shall be sent for further pathologic examination and the patient alerted to the possibility of an ectopic pregnancy.

E. A written report of each laboratory test and examination shall be a part of the patient's record.

F. If a patient is bleeding profusely and a transfusion of red blood cells is necessary, she should be administered fluids and transported immediately to a hospital that routinely performs crossmatches and transfuses patients.

G. All laboratory supplies shall be monitored for expiration dates, if applicable.

H. Products of conception resulting from the abortion procedure must be managed in accordance with requirements for pathological waste pursuant to Department Regulation 61-105, Infectious Waste Management Regulations. All contaminated dressings and/or similar waste shall be properly disposed of in accordance with Regulation 61-105.

SECTION 305. Emergency Care (I)

A. All staff and/or consulting physicians shall have admitting privileges at one or more local hospitals that have appropriate obstetrical/gynecological services or shall have in place documented arrangements approved by the Department for the transfer of emergency cases when hospitalization becomes necessary.

B. Equipment and services shall be provided to render emergency resuscitative and life-support procedures pending transfer of the patient to a hospital.

C. The facility shall inform, in writing, the local ambulance service which provides emergency care and transport of patients, of the location of the facility, and the nature of medical problems which may result from abortions.

SECTION 306. Equipment and Supplies (II)

There shall be appropriate equipment and supplies maintained for the patients to include but not limited to:

A. A bed or recliner suitable for recovery;

B. Oxygen with flow meters and masks or equivalent; (I)

C. Mechanical suction; (I)

D. Resuscitation equipment to include, as a minimum, resuscitation bags and oral airways; (I)

E. Emergency medications, intravenous fluids, and related supplies and equipment; (I)

F. A clock with a sweep second hand;

G. Sterile suturing equipment and supplies;

H. Adjustable examination light;

I. Containers for soiled linen and waste materials with covers;

J. Refrigerator;

K. Appropriate equipment for the administering of general anesthesia, if applicable.

SECTION 307. Consultation (II)

Arrangements shall be made for consultation or referral services in the specialties of obstetrics/gynecology, anesthesiology, surgery, psychiatry, psychology, clinical pathology and pathology, clergy, and social services, as well as any other indicated field, to be available as needed.

SECTION 308. Quality Improvement (II)

A. The facility shall establish and implement a written plan for a quality improvement program for patient care. The plan shall specify the individual responsible for coordinating the quality improvement program and shall provide for ongoing monitoring of staff and patient care services.

B. There shall be an ongoing process for monitoring and evaluating patient care services, staffing, infection prevention and control, housekeeping, sanitation, safety, maintenance of physical plant and equipment,

patient care statistics, and discharge planning services.

C. Evaluation of patient care throughout the facility shall be criteria-based, so that certain actions are taken or triggered when specific quantified, predetermined levels of outcomes or potential problems are identified.

D. The quality improvement process shall incorporate quarterly review of a minimum of five per cent of medical records of patients undergoing procedures during a given quarter, but not less than five records shall be reviewed.

E. The quality improvement process shall include evaluation by patients of care and services provided by the facility. If the families of patients are involved in the care and services provided by the facility, the quality improvement process shall include a means for obtaining input from families of patients.

F. The administrator shall review the findings of the quality improvement program to ensure that effective corrective actions have been taken, including as a minimum, policy revisions, procedural changes, educational activities, and follow-up on recommendations, or that additional actions are no longer indicated or needed.

G. The quality improvement program shall identify and establish indicators of quality care, specific to the facility, that shall be monitored and evaluated.

H. The results of the quality improvement program shall be submitted to the licensee for review at least annu-

ally and shall include at least the deficiencies found and recommendations for corrections or improvements. Deficiencies that jeopardize patient safety shall be reported immediately in writing to the licensee.

SECTION 309. Requirements for Clinics Performing Abortions Beyond 14 Weeks (I)

Clinics which perform abortions beyond 14 weeks from the first day of the last menstrual cycle shall, in addition to those requirements in all other sections of this regulation, have the following in place:

A. Physicians shall be board-certified or a candidate for board-certification in obstetrics and gynecology, general surgery, or family practice;

B. Physicians shall have admitting privileges at one or more local hospitals that have appropriate obstetrical/gynecological services;

C. Laryngoscopes, endotracheal tubes, and defibrillator;

D. Laboratory tests/procedures shall include:

1. White blood count and determination of blood type;

2. Sickle cell, when indicated;

3. Ultrasonogram.

CHAPTER 4 - MEDICAL RECORDS AND REPORTS

SECTION 401. Medical Records (II)

Medical records shall be maintained for all patients examined or treated in the clinic. The records shall be completely and accurately documented, readily available, and systematically organized to facilitate the compilation and retrieval of information. All information shall be centralized in the patient's medical record. All entries shall be legibly written or typed, dated and signed.

A. The record shall include as a minimum the following information:

1. A face sheet with patient identification data, to include but not be limited to: name, address, telephone number, social security number, date of birth, father's and mother's names when patient is a minor, husband's name, and name, address and telephone number of person to be notified in the event of an emergency;

2. Signed consent for the procedure;

3. Date of initial examination;

4. Date of abortion;

5. Referring and attending physicians' names and phone numbers, if applicable;

6. Complete medical history to include medications currently being taken;

7. Physical examination, to the extent necessary to determine the health status of the patient, within 15 days of the procedure, including detail of findings of pelvic examination and estimated gestational age, according to the first day of the last menstrual period;

8. Results of diagnostic tests and/or examinations, e.g., X-ray, electrocardiography, clinical laboratory, pathology, consultations, ultrasound;

9. Pre-operative diagnosis;

10. Counselor's notes;

11. Physician's orders;

12. Complete record of abortion procedure to include:

    a. Vital signs, i.e., temperature, pulse, respiration, and blood pressure, prior to and following the procedure;

    b. Name of procedure performed;

    c. Anesthetic agent utilized;

    d. Name of attending physician performing the procedure;

    e. Names of clinical assistants in attendance, to include other physicians, physician's assistants, anesthetists, nurses, or specially-trained technicians;

f. Signature of physician performing the procedure.

13. Nurses' notes;

14. Progress notes to include a post-anesthesia note if general anesthesia is utilized;

15. Attending physician's description of gross appearance of tissue removed;

16. Final diagnosis;

17. Condition on discharge;

18. Post-op orders and follow-up care;

19. Documented verification that the woman has been presented printed materials as required in the Woman's Right-to-Know Act;

20. In the case of an unemancipated minor or mentally incompetent person, a copy of the court order or written consent authorizing the abortion.

B. The attending physician must complete and sign the medical record within 72 hours following discharge.

SECTION 402. Records Storage

All records shall be treated as confidential and shall be stored in a safe location for a minimum of 10 years. When records are stored in a location other than the clinic, and upon closure of the clinic, for any reason, the medical records shall be stored in a safe location for that minimum period, with the Department informed of that location. The medium in which

the records are stored, e.g., optical disk, microfiche, is a facility decision.

SECTION 403. Reports (II)

A. The following shall be reported to Vital Records and Public Health Statistics of this Department:

1. Any abortion performed, to be reported by the performing physician on the standard form for reporting abortions, within seven days after the abortion is performed;

2. A fetal death when the fetus has completed or passed the age or weight requiring a report, pursuant to the standards in Regulation 61-19, Vital Statistics.

B. A record of each accident or incident occurring in the facility which involves patients, staff, or visitors, including medication errors and adverse drug reactions, shall be prepared immediately. Accidents or incidents resulting in serious injury shall be reported, in writing, to the Department within 10 days of the occurrence; if a death occurs, other than a fetal death, it shall be reported to the Department not later than the next Department work day (Monday through Friday). Accidents and incidents that must be reported include, but are not limited to:

1. Those leading to hospitalization;

2. Those leading to death, other than a fetal death;

3. Adverse drug reactions.

CHAPTER 5 - FUNCTIONAL SAFETY AND MAINTENANCE (II)

SECTION 501. Policies and Procedures

A. Written policies and procedures shall be developed to enhance safety within the facility and on its grounds and to minimize hazards to patients, staff and visitors.

B. The policies and procedures shall include, but not be limited to:

1. Safety rules and practices pertaining to personnel, equipment, gases, liquids, drugs, supplies and services;

2. Provisions for reporting and investigating accidental events regarding patients, visitors and personnel and corrective action taken;

3. Provisions for disseminating safety-related information to employees and users of the facility;

4. Provision for syringe and needle handling and storage.

5. Provisions for managing infectious waste from generation to disposal according to Regulation 61-105.

SECTION 502. Disaster Preparedness

A. The facility shall have posted, in conspicuous places throughout the facility, a plan for evacuation of patients, staff, and visitors in case of fire or other emergency. (I)

B. A facility that participates in a community disaster plan shall establish plans, based on its capabilities, to meet its responsibilities for providing emergency care.

SECTION 503. Maintenance

A. Facility Maintenance. A facility's structure, its component parts, and all equipment such as elevators, furnaces and emergency lights, shall be kept in good repair and operating condition. Areas used by patients shall be maintained in good repair and kept free of hazards. All wooden surfaces shall be sealed with non-lead-based paint, lacquer, varnish, or shellac that will allow sanitization.

B. Equipment Maintenance. When patient monitoring equipment is utilized, a written preventive maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, not less than annually, to insure proper operation and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper operation before returning it to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance.

CHAPTER 6 - INFECTION CONTROL AND SANITATION (II)

SECTION 601. General

Policies and procedures shall be established in writing to assure safe and aseptic treatment and protection of all patients and personnel against cross-infection.

SECTION 602. Sterilization Procedures

A. Adequate space shall be provided for storage, maintenance and distribution of sterile supplies and equipment.

B. Sterile supplies and equipment shall not be mixed with unsterile supplies, and shall be stored in dust-proof and moisture-free units. They shall be properly labeled.

C. Sterilizing equipment of appropriate type shall be available and of adequate capacity to properly sterilize instruments and materials. The sterilizing equipment shall have approved control and safety features.

1. There must be documentation of each load run daily. A biological test of the autoclave shall be run daily and the results maintained on a log.

2. Each separate package of instruments to be sterilized must have internal and external chemical indicators.

3. The accuracy of instrumentation and equipment shall be provided by periodic calibration and/or

preventive maintenance as necessary, but not less than annually, and a log maintained.

D. The policies and procedures shall indicate how the shelf life of a packaged sterile item is determined. Methods approved for use are:

1. Date of expiration being marked on the item; or

2. Event-related, i.e., day-to-day expiration, utilizing such wording as, "sterile unless the integrity of the package is compromised."

SECTION 603. Linen and Laundry

A. An adequate supply of clean linen or disposable materials shall be maintained in order to insure change of linen on procedure tables between patients.

B. Provisions for proper laundering of linen and washable goods shall be made. Soiled and clean linen shall be handled and stored separately. Storage shall be in covered containers.

C. A sufficient supply of cloth or disposable towels shall be available so that a fresh towel can be used after each handwashing. Towels shall not be shared.

SECTION 604. Housekeeping

A. General. A facility shall be kept neat, clean and free from odors. Accumulated waste material must be removed daily or more often if necessary. There must be frequent cleaning of floors, walls, ceilings, woodwork, and windows. The premises must be kept free from rodent and insect infestation. Bath and toilet fa-

cilities must be maintained in a clean and sanitary condition at all times.

B. Cleaning materials and supplies shall be stored in a safe manner. All harmful agents shall be locked in a closet or cabinet used for this purpose only.

C. Dry sweeping and dusting of walls and floors are prohibited.

SECTION 605. Refuse and Waste Disposal

A. All garbage and waste shall be collected, stored and disposed of in a manner designed to prevent the transmission of disease. Containers shall be washed and sanitized before being returned to work areas. Disposable type containers shall not be reused.

B. Containers for garbage and refuse shall be covered and stored outside and placed on an approved platform to prevent overturning by animals, the entrance of flies or the creation of a nuisance. All solid waste shall be disposed of at sufficient frequencies in a manner so as not to create a rodent, insect or other vermin problem.

C. Immediately after emptying, containers for garbage shall be cleaned.

D. All waste meeting the definition of "infectious waste" as defined in Regulation 61-105 must be managed according to the requirements of that regulation.

SECTION 606. Outside Areas

All outside areas, grounds and/or adjacent buildings shall be kept free of rubbish, grass, and weeds that may serve as a fire hazard or as a haven for insects, rodents and other pests. Outside stairs, walkways, ramps and porches shall be maintained free from accumulations of water, ice, snow and other impediments.

CHAPTER 7 - FIRE PROTECTION AND PREVENTION (I)

SECTION 701. Fire-fighting Equipment and Systems

A. All facilities located outside a fire protected area shall have a contract with the nearest fire department.

B. An evacuation plan shall be posted in prominent places and staff members shall be trained as part of their responsibilities to guide patients to the designated exits.

C. All fire protection and alarm systems and other fire fighting equipment shall be inspected and tested at least once each year, and more often if necessary to maintain them in serviceable condition.

D. Fire extinguishers of the proper type shall be installed in accordance with NFPA 10 (National Fire Protection Association) 10 requirements or as otherwise directed by fire authorities.

   1. Fire extinguishers shall be kept in condition for instant use and shall be inspected monthly by facility staff with the date of inspection recorded on a tag affixed to the extinguisher.

2. Fire extinguishers shall be inspected and/or serviced annually by personnel licensed or certified to perform fire extinguisher servicing. Servicing/inspection records shall be kept on the fire extinguishers.

E. No portable electric, open flame, or unvented heaters shall be allowed in the facility.

F. Fire Drills.

1. A fire drill shall be conducted at least once every three months. New facilities shall conduct a fire drill within the first 48 hours of operation. Each employee shall participate in a fire drill at least twice each year.

2. Records of drills shall be maintained to report the date, time, description, and evaluation of the drill, to include the names of participating staff and time for total evacuation.

G. Corridor Obstructions. All corridors and other means of egress or exit from the building shall be maintained clear and free of obstructions.

H. Corridor and Stairway Illumination. Corridors, stairs and other means of egress shall be lighted at all times with a minimum of one foot-candle at finish floor level along the path of travel.

SECTION 702. Alarms

A fire alarm system shall be provided in accordance with the provisions of NFPA 72. The fire alarm system shall be

tested monthly and each detector tested annually. Records of all tests shall be retained for at least one year.

SECTION 703. Gas Storage

Gases (flammable and nonflammable) shall be handled and stored in accordance with the provisions of applicable NFPA codes.

CHAPTER 8 - DESIGN AND CONSTRUCTION

SECTION 801. General

Every facility must be planned, designed and equipped to provide adequate facilities for the care and comfort of each patient.

SECTION 802. Local and State Codes and Standards (II)

A. Facilities shall comply with pertinent local and state laws, codes, ordinances and standards with reference to design and construction. Abortion clinics are categorized as a "business occupancy" as defined in the Standard Building Code. No facility will be licensed unless the Department has assurance that responsible local officials have approved the facility.

B. The Department uses as its basic codes: the Standard Building Code, Standard Plumbing Code, Standard Mechanical Code, and National Electrical Code. Buildings designed in accordance with the above mentioned codes will be acceptable to the Department, provided, however, that the requirements set forth in this regulation are also met.

SECTION 803. Submission of Plans and Specifications

A. New Buildings, Additions or Major Alterations to Existing Buildings. (II)

1. When construction is contemplated either for new buildings, additions or major alterations to existing buildings, the facility must contact the Division of Health Facilities Construction of this Department to discuss code and regulation requirements that apply to that project. Plans and specifications shall be submitted to the Department for review. Where the Standard Building Code or other regulations require fire-rated walls or other fire-rated structural elements, these plans and specifications shall be prepared by an architect registered in the State of South Carolina and shall bear his/her seal.

2. All plans shall be drawn to scale with the title and date shown thereon. Construction work shall not be started until approval of the final drawings or written permission has been received from the Department. Any construction changes from the approved documents require approval by the Department.

B. Preliminary submission shall include the following:

1. Plot plan showing size and shape of entire site; orientation and location of proposed building; location and description of any existing structures, adjacent streets, highways, sidewalks, railroads, et cetera, properly designated; size, characteristics and location of all existing public utilities, in-

cluding information concerning water supply available for fire protection;

2. Floor plans showing overall dimensions of buildings; locations, size and purpose of all rooms; location and size of doors, windows and other openings with swing of doors properly indicated; locations of smoke partitions and firewalls; locations of stairs, elevators, dumbwaiters, vertical shafts and chimneys;

3. Outline specifications listing a general description of construction including interior finishes and mechanical systems.

C. Final submission shall include the following: Complete working drawings and contract specifications, including layouts for plumbing, air conditioning, ventilation and electrical work and complete fire protection layout, if applicable.

D. In construction delayed for a period exceeding 12 months from the time of approval of final submission, a new evaluation and/or approval is required.

E. One complete set of as-built drawings shall be filed with DHEC.

SECTION 804. Licensure of Existing Structures (II)

When an existing structure is contemplated for licensure it must meet the same building code requirements as a "new" facility (see Section 803.A). If an expansion or renovation to an existing facility is contemplated, the facility must contact the Division of Health Facilities Construction of this Department to discuss code and regulatory requirements that

apply to that project. The following shall be submitted to the Department:

A. If the physical dimensions of the building are affected, a plot plan in accordance with Section 803.B.1;

B. A floor plan in accordance with Section 803.B.2;

C. Description of construction including outside walls, partitions, floor, ceiling and roof. The method of heating and cooling shall also be included.

NOTE: Those existing abortion clinics that have been identified by the Department, through submission of regular reports of abortions performed, may be licensed in their current buildings. However, upon initial licensure, these facilities will be required to submit a plan that will bring them into full compliance with this chapter within two years from date of licensure.

SECTION 805. Minor Alterations in Licensed Facilities

When alterations that involve construction that may affect walls, ceilings, floors, or fire and life safety are contemplated, preliminary drawings and specifications, accompanied by a narrative completely describing the proposed work, shall be submitted to the Department for review and approval to insure that the proposed alterations comply with current safety and building standards and determine if an architect need be involved.

SECTION 806. Location

A. Transportation. The facility must be served by roads that are passable at all times and are adequate for the volume of expected traffic.

B. Parking. The facility shall have parking space to reasonably satisfy the needs of patients, staff, and visitors.

C. Communications. A telephone must be provided on each floor used by patients and additional telephones or extensions must be provided, as required, to summon help in case of fire or other emergency. Pay station telephones are not acceptable for this purpose.

SECTION 807. Physical Facilities

A. An adequate number of examination/procedure rooms shall be provided. A procedure room shall be sized, shaped, and arranged to allow unfettered movement for all persons involved in the procedure.

B. Each procedure room shall be provided:

1. A suitable gynecological procedure table;

2. Equipment necessary to treat patients for hemorrhage, shock, cardiac arrest and other emergencies (an emergency "crash" cart in the immediate vicinity is acceptable); (I)

C. An area shall be provided for use by nurses in preparing medications for patients and keeping patient medical records. A room or cabinets shall be provided for storing medications and shall be kept locked

except when medications are being prepared for administering. Narcotics shall be double-locked. An adequate supply of drugs shall be on hand at all times.

D. An adequate number of recovery room(s) or area(s) shall be provided. There shall be clear space on both sides and at the foot of each recovery bed/recliner to allow unencumbered movement by staff and patients.

1. There shall be a toilet room immediately accessible from the recovery area. This room shall contain a commode with grab bars or recessed hand-holds and handwashing lavatory, operable without the use of hands, soap dispenser with soap, and paper towel dispensers with paper towels, or hot air dryer;

2. There shall be a signal system for each patient bath and toilet that shall include an audible alarm that can be heard and location identified by staff;

3. There shall be a readily accessible safe and sanitary storage area for patients' clothing and personal effects;

4. There must be provisions to afford privacy upon request of a patient, e.g., curtains, screens, private room.

E. A room for the temporary storage of soiled linen and waste in covered containers shall be provided. This room shall be provided with at least 10 air changes per hour with all air continuously exhausted to the outside.

F. There must be an area to accommodate the sterilization procedures as described in Section 602. There shall be sufficient surgical instruments sterilized and available for each patient who presents herself for abortion. The area shall be arranged to prevent cross traffic of clean and dirty material. Air flow in this area shall be from the "clean" area toward the "dirty" area.

G. Suitable dressing room space shall be provided for physicians and nursing staff. Scrub facilities shall be provided and located conveniently to the procedure room(s).

H. Procedure and recovery room(s) shall be located on an exit access corridor that provides unimpeded, rapid access to an exit of the building. This exit must accommodate emergency transportation vehicles and equipment.

I. In multi-storied buildings where the facility is not located on the floor of entry to/exit from the building, there must be at least one elevator that serves the clinic floor(s). The elevator must accommodate emergency transportation equipment.

J. Adequate fixed or portable work surface areas shall be maintained for use in each procedure room.

K. Doors providing access into the facility and procedure room(s) shall be at least 36 inches wide to accommodate maneuvering of ambulance stretchers and wheelchairs and other emergency equipment. All corridors shall be at least 48 inches wide.

L. Heating and ventilation.

1. Lighting, heating, and ventilation systems shall comply with local and state codes. There shall be approved equipment capable of maintaining a minimum temperature of 72 degrees Fahrenheit and a maximum temperature of 76 degrees Fahrenheit in patient areas.

2. The procedure room(s) and the recovery room(s) shall be provided a minimum of six air changes per hour. Air supplied to all areas shall be filtered through filters of at least 25 percent efficiency rating.

3. Mechanically operated systems shall be used to supply air to and exhaust air from soiled workrooms or soiled storage areas, janitor's closets, toilet rooms, and from spaces that are not provided with operable windows or outside doors.

M. The entrance shall be at grade level or above, be sheltered from the weather, and accommodate wheelchairs.

N. There shall be adequate storage areas for supplies and other storage. Sterile supplies shall be stored separate from other supplies.

O. One or more janitor's closets shall be provided throughout the facility as required to maintain a clean and sanitary environment. Each shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies.

P. A clean work area shall contain space for handwashing and clean storage and may include clean linen storage.

Q. There shall be at least two exits remote from each other.

R. Items such as drinking fountains, machines, and portable equipment or any other items shall not be located in the required exit corridors to restrict corridor traffic.

S. Thresholds and expansion joint covers shall be made sufficiently flush with the floor surface to accommodate wheeled service carts, wheelchairs, gurneys, etc.

T. All corridor glazing materials that extend within 18 inches of the floor shall be of safety glass, plastic, wireglass, or other material that will resist breaking and will not create dangerous cutting edges when broken. Safety glass or plastic glazing materials shall be used for any shower doors or bath enclosures.

U. Cubicle curtains and draperies shall be noncombustible or rendered flame retardant.

V. Wall finishes shall be washable and, in the immediate area of plumbing fixtures, shall be smooth and moisture resistant.

W. Wall bases in soiled equipment and material workrooms and other areas that are frequently subject to wet cleaning methods shall be tightly sealed and constructed without voids that can harbor insects.

X. Floor and wall penetrations by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.

Y. Interior finish materials shall comply with the Standard Building Code requirements for "business occupancy."

Z. Adequate space shall be provided for reception, waiting, interviewing, administrative, and business office functions. Space provided for interviewing and admitting shall be located and designed to provide privacy.

SECTION 808. Water Supply and Plumbing (II)

A. Water Supply. Water shall be obtained from a community water system and shall be distributed to conveniently located taps and fixtures throughout the facility and shall be adequate in volume and pressure for all purposes including fire fighting. Patient and staff handwashing lavatories shall be supplied with hot water that shall be thermostatically controlled to a temperature between 100 and 125 degrees Fahrenheit.

B. Plumbing.

1. All plumbing material and plumbing systems or parts thereof installed shall meet the minimum requirements of the Standard Plumbing Code.

2. All plumbing shall be installed in such a manner as to prevent back siphonage or cross-connections between potable and non-potable water supplies. There shall be, at a minimum, an approved dou-

ble-check assembly on the water supply to the facility.

SECTION 809. Emergency Power and Lighting Requirements

A. The facility shall be equipped with automatic emergency power adequate to maintain the operation of lighting for procedure rooms, egress, fire detection equipment, and alarms. (I)

B. There shall be sufficient safe lighting for all activities, including suitable lighting for corridors. (II)

CHAPTER 9 - PREREQUISITES FOR INITIAL LICENSURE

Prior to admission of patients to, and issuance of a license for new facilities or additional procedure rooms, the following actions must be accomplished:

A. Plans and construction must be approved by the Division of Health Facilities Construction of this Department.

B. The facility shall submit a completed application for license on forms that shall be furnished by the Division of Health Licensing. The following documents shall be submitted with the application:

1. Final construction approval of both water and wastewater systems by the appropriate District Environmental Quality Control Office of this Department (includes satisfactory laboratory reports of water samples).

2. Approval from the appropriate building official stating that all applicable local codes and ordinances have been complied with.

   a. If the facility is located within town or ~~city~~ limits, approval by the local fire chief stating that all applicable requirements have been met, or

   b. If the facility is located outside town or city limits, a written letter of agreement with the nearest fire department that will provide protection and respond in case of fire at the facility shall be obtained. This letter shall indicate that they have the equipment, personnel, and/or agreements with other departments to adequately respond to this type of facility.

3. Certification and laboratory test reports, provided by the manufacturer or supplier, that all carpeting purchased by the facility meets the requirements of the Standard Building Code.

4. Certification by the contractor that only the carpeting described in B.3 above was installed in the facility.

5. Certification by the manufacturer or supplier that all drapes and cubicle curtains purchased by the facility are flame or fire resistant or retardant.

6. Certification by the owner or contractor that only materials described in B.5 above were installed.

7. Certification by the manufacturer or supplier that all wall covering materials purchased by the facility are fire or flame resistant or retardant.

8. Certification by the contractor that only the materials described in 7 above were installed.

9. Certification by the engineer that all fire alarm and smoke detection systems have been installed according to plans and specifications, have been tested and operate satisfactorily.

10. Certification by the contractor that the automatic sprinkler system, if required or installed, has been completed and tested in accordance with the approved plans and specifications and NFPA No. 13. Include a copy of the approval letter of the sprinkler shop drawings.

11. Certification that all medical gas systems have been properly installed and tested.

C. The facility must register as an infectious waste generator as outlined in Regulation 61-105.

D. Required personnel must be employed, available, trained, and capable of performing their duties.

E. The Division of Health Licensing shall inspect the facility and require compliance with these regulations.

F. The facility must pay the required licensing fee.

CHAPTER 10 - GENERAL

Conditions arising that have not been addressed in these regulations shall be managed in accordance with the best practices as interpreted by the Department.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPTS FROM DEPOSITION OF
RICHARD GOODRICH
DECEMBER 15, 1997

[66]
9 I can't comment on this. I don't know how
10 you decide somebody is qualified.

***

[68]
12 A. I can see in writing regulations like this
13 It would be unduly restrictive because there are a
14 lot of physicians that are licensed and do not have
15 specialty training that could be capable of doing
16 the procedures, pelvic procedures. And I have known
17 through my experience — I don't know how
18 you go out and identify the people that are capable
19 of that, you know, if you don't have something to
20 look at.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPT FROM DEPOSITION OF
ROBERT A. LAWYER
FEBRUARY 3, 1998

[83]

A. Well, I think that would be courtesy. But a list would be fine. That's a referral.
Q. That would satisfy this requirement?
A. I believe it would.
Q. So they could basically have the yellow pages sections for these specialties?
A. That's carrying it a little far.
Q. It wouldn't satisfy you, if you were an inspector?
A. It would be a list, but I think I would look for something a little more concise.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPT FROM DEPOSITION OF
RICHARD O. MANNING
FEBRUARY 4, 1998

[45]

Q. Geographically, you indicated earlier, they come from all different parts of the state of South Carolina?
A. Yes.
Q. Is there one area they predominantly come from?
A. The area around Charleston, but we get them all the way from Georgia, North Carolina, and routinely see people from Columbia, quite often also from Greenville.
Q. Again, in some of those cities there are abortion facilities?
A. Yes.
Q. So they travel to your clinic because of its reputation?
A. Yes. Like in Greenville they always have picketers, so a lot of the people in Greenville don't want to walk through the picketers and get their picture taken so they will come to Charleston. Then I feel sure there are people from Charleston that drive to Greenville.
Q. For confidentiality purposes?
A. Confidentiality, yes.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPTS FROM TRIAL TESTIMONY OF
WILLIAM LYNN
JULY 14, 1998

[165]

Q. Referring you down to 102.F.2 on that same page. Do you have concerns with regard to that section?
A. Yes, I do. It says, "Department inspectors shall have access to all properties, area, objects and records and reports." And this seems to be a violation of the patient's privacy and the referring physician's privacy, since it also requires that we record the referring physician later in the regulations, and could be detrimental to the doctor-patient relationship which is very important.
Q. And do you have any other concerns with reference to that section?
A. They're also allowed to make photocopies for the same ---
Q. You understand that to allow them to make photocopies of any of the records in the office?
A. Yes.

[166]

Q. That would include patients' records?
A. I assume that's what that means, yes.
Q. What are your concerns with reference to their being able to make photocopies of those documents?

A. I see no purpose of making photocopies if you're not going to remove them. And if they're taken and removed from my office, I lose control over any confidentiality I have with any of my patients.

***

[223]
understand. But section E requires that if the families of patients are involved in the care and services provided for the facility, there must be a means to obtain input from the families of the patients. And I really don't quite understand what that means. On the surface, I may. But our patients are frequently accompanied to the clinic by family and friends. Whether that constitutes involvement, the fact that they just come and accompany them and give them moral support or not, I'm not sure. I have had in the past some patients accompanied to my facilities by a family member who has absolutely no idea why she's there, and the patient does not want them to know. And this may require
[224]
breaking the confidentiality in letting them know why they're there when it's not desired by the patient.

***

[319]
them. But in Greenville, we have a tremendous problem with

harassment of patients and employees by antiabortion protestors. They've purchased the building next-door. They single out my employees as they come in. In the past, I've had these people write to my employees at home, call

[320]

them at home, protest in front of their homes. And many of my employees come and work for two or three days and leave, which I don't know is responsible – or I don't know is as a result of that, but I have very strong feelings that they don't want to put up with the harassment.

Q. And when you're referring to "they" picketing in front of employees homes, you're referring to the antiabortion persons doing so?

A. The same persons that protest in front of my office, antiabortion protestors.

Q. Is the level of protest activity associated with your Greenville facility higher than at your Beaufort facility?

A. Much higher.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPTS FROM TRIAL TESTIMONY OF
THOMAS W. CAMPBELL
JULY 14, 1998

[371]

Q. Let me back up one more time to 102.F, which is on page six.
A. This having inspections just further decreases confidentiality of the patients. The Clinical Lab Enforcement Act comes in once every two years and they have access to any patient records. This would put some other person who may be antiabortion, pro-choice, whatever, you don't know what their status would be coming into your office looking over folks' records.

***

[420]

know, they'd be there at quarter till seven. I wouldn't want to – you'd have to get everybody there before you'd know there would be any patients because any kind – abortion clinics are – you know, there have been bomb threats, we have problems with protestors, we have all kinds of things. I wouldn't want to upset the patients as far as if I set off alarms and people go running out of the clinic and practicing this with all the patients there. I'd rather do it when they weren't.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPTS FROM TRIAL TESTIMONY OF
LORRAINE D. MAGUIRE
JULY 15, 1998

[451]

Q. And have you, based on your experience working in abortion clinics, found that some patients – you mentioned that some patients from Beaufort come to your clinic. Have you found that sometimes patients seem to prefer not to go to a clinic in their own town?
A. Yes.
Q. Do you have an understanding as to why that is?
A. Confidentiality.

***

[457]

Q. Referring you now to 102.F, right below it. Do you have concerns with regard to the requirements set forth in 102 F?
A. I think that's vague to the point that I'm not sure when these inspections would take place, if it would take place during the normal day that we see patients and interfere with that.
Q. And referring you specifically also to 102.F Sub 2, do you have any concerns with respect to that provision?
A. It concerns me that DHEC could come in and, for

25 whatever reason, photocopy and remove documents from the
[458]
1 clinic. We have protestor problems in Charleston and they
2 have in the past gotten information from DHEC and brought
3 it back to the clinic and passed it out on the streets.
4 Q. And how do you know that protestors have obtained
5 documents from DHEC?
6 A. There is an induced termination of pregnancy report
7 that we're required to fill out on every abortion that we
8 do. One of my main protestors has gone to Columbia on
9 numerous occasions and made copies of several days' worth
10 of documents, brought them back, Xeroxed them on the back
11 of a letter that she passed out in my neighborhood.
12 Q. I'd like to hand you what's been marked as plaintiff's
13 exhibit eleven and plaintiff's exhibit twelve.
14 MR. ELLIOTT: Your Honor, we had interposed an
15 objection to plaintiff's exhibit twelve.
16 THE COURT: What is your objection?
17 MR. ELLIOTT: If your honor has a copy of it, it
18 might make more sense. Your honor, this is an exhibit that
19 is not a business record of the Charleston Women's Clinic.
20 As Ms. Maguire just testified, it was handed out in her
21 neighborhood. It's not signed by anybody, although it does
22 have the name of an organization on it. It's not addressed
23 to anybody. As a result, Your Honor, it's impossible to
24 authenticate, number one. And in addition, Your Honor,
25 it's not relevant because it does not go to any issue
[459]

involving Regulation 61-12.

THE COURT: It's relevant to the question of whether or not you have a legitimate concern about the ability of DHEC to keep this information confidential. Objection is overruled.

MS. ANDERSON: Thank you, Your Honor.

DIRECT EXAMINATION RESUMED BY MS. ANDERSON:

Q. Ms. Maguire, referring you to what I've just handed you as plaintiff's exhibit eleven and exhibit twelve, do you recognize these documents?

A. Yes.

Q. Have you seen these documents before?

A. Yes.

Q. When you first saw some other copy of these documents, were they two separate sheets or not?

A. No. They were one sheet Xeroxed front and back.

Q. So actually what is marked as twelve was on the back side of what's marked as eleven?

A. Yes.

Q. And how did you obtain a copy of this, what was then a two-sided, one-page document?

A. Off of my mailbox.

Q. And when you were just testifying regarding a protestor at your facility who had, to your knowledge, obtained documents that had been filed with DHEC, was this

[460]

document one that you were referring to?

A. Yes. And it's an accurate document, except for at the bottom where it says "problems after an abortion," that's a small business type card that they placed over a portion of

this paper and Xeroxed it. That's not part of the \
document.
Q. And when you're referring to the document, you're referring to what's specifically marked as exhibit eleven?
A. Eleven.
Q. So, in fact, with that exception you've just noted, exhibit eleven is indeed a copy of a document that your clinic had filed with DHEC?
A. Yes.

***

[500]
Q. Now, you have offered into evidence here a document that looks like an abortion procedure has been performed. Do you know where that came from? I don't remember the exhibit number off the top of my head, but I think it's either eleven or twelve.
A. Eleven.
Q. Yes, ma'am. That one you're holding. Do you know where it came from?
A. We fill out this form after the abortion is performed in our facility. And then it's sent to vital records at DHEC.
Q. That's the Bureau of Vital Statistics?
A. Yes.
Q. Do you know where that came from?
A. Yes. One of my protestors goes to Columbia, goes through the forms for any particular day, sometimes several days, she pays to get copies of these forms and then she brings them back. And sometimes she passes them out on the street, sometimes she just sends them into the building to
[501]

show me she knows how many abortions were performed.
In this particular case, she Xeroxed this on the back of a letter that she passed out to everybody in my neighborhood.
Q. Can I see that just a second? Do you know if this still is occurring?
A. What do you mean still current?
Q. Is this – do you still see these forms today, last week?
A. We still do those.
Q. Has there been any public dissemination of it, to your knowledge, after this incident?
A. Certainly. She periodically brings them.
Q. Now, this simply shows that an abortion was performed and has no names; is that correct?
MS. ANDERSON: Excuse me. Could I just ask that if he's going to ask the witness about the exhibit that he make sure she can see it.
MR. RICHARDSON: I'm going to hand it back to her. I was walking up there.
MS. ANDERSON: Thank you.
CROSS-EXAMINATION RESUMED BY MR. RICHARDSON:
Q. It has no names or identifying information other than a county; is that correct?
A. It has a number that we can identify, a patient chart number, and then the rest of it is just statistical

[502]

information. Recently, in Charleston, we had a patient that was sixteen years old that gave a zip code in the City of Charleston to a certain school district. And our protestor went there and protested at that high school

based on the zip code that she got off of one of these forms.
Q. And it's your testimony that you've seen those recently, in the last year?
A. Yes.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPTS FROM TRIAL TESTIMONY OF
DAVID A. GRIMES
JULY 16, 1998

[729]

Q. And, Dr. Grimes, are you familiar with certain provisions of Regulation 61-12 that permit the Department of Health and Environmental Control to inspect abortion facilities and review and photocopy patient records in abortion facilities?

A. That was perhaps the most outrageous aspect of this document, from my perspective as a clinician with a quarter century experience.

Q. Why is that?

A. Absolutely outrageous violation of patient confidentiality. The notion that someone from Columbia can come in and start Xeroxing patient charts with identification, I wouldn't let them in the door.

***

[732]

Q. I'm sorry. I'm on page eleven, section 205.C.1. Can you tell me if you understand what qualifications, other than a license, a physician would need to have in order to be able to perform abortions in this state?

A. Well, I can't infer that by reading this sentence. It

says, "Who are properly qualified by training and experience." That's vague to me. So I can't answer.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPTS FROM TRIAL TESTIMONY OF
GEORGE MOORE
JULY 16, 1998

[854]
25 Q. Could you look at Section 205.C.1 relating to the
[855]
1 qualifications of physicians. That section actually
2 requires the DHEC inspector to evaluate the training and
3 experience of a doctor to determine whether they're
4 qualified to perform abortions; is that correct?
5 A. Yes.
6 Q. And that assessment would be made on a
7 case-by-case basis by the inspector?
8 A. Yes.

***

[863]
3 Q. Well, what are the best practices as interpreted by
4 the department? What does that mean?
5 A. I think that that would have to be a case-by-case call
6 on the part of the inspector.
7 Q. Okay. Are you saying that anything that an inspector
8 found to be against the best practices as interpreted by
9 the department would have to be specifically included or
10 referenced in Regulation 61-12?
11 A. I don't – I'm not sure I understand your question
12 again. Please repeat it.
13 Q. Okay. I'm trying to figure out the best practices

that I guess can be violated under this particular section, whether those best practices are things that are described or identified in this regulation or whether they are things that exist outside the world of this regulation.
A. Well, I feel like that we would certainly classify – or let's just don't even say classify – interpret something that's seen that is not specifically referred to in the regulation as something that needs to be looked into. Usually what we do in cases like that when it's absolutely not covered anywhere else, we would go to the general paragraph which is at the end of the reg. I think that's essentially what we're talking about here, that that

[864]

would be a class three violation because part ten generally also talks about the best practices.
Q. Okay. So, in other words, a provider could commit a class three violation by doing something that is not, according to the words and terms of this regulation, prohibited?
A. If something is really seriously wrong in the eyes of the inspector that's not covered in a specific standard, we always have that option.
THE COURT: That question needs to be answered specifically yes or no. Repeat the question, please.
DIRECT EXAMINATION RESUMED BY MS. JONES:
Q. What I would like to know is whether the best practices, the violation of which can constitute a class three violation, whether those best practices are described and/or identified in this regulation?
A. No.

***

[873]

Q. I don't even know what it was anymore. I think my question was I believe that you stated previously that under this section, a physician would have to make prior arrangements with consultants ahead of time to insure that those consultants were immediately available should the physician wish to refer a patient to them; is that correct?
A. That's the intent of this section.
Q. That is your understanding?
A. That's my understanding.
Q. Could you – let me ask you one more thing. In the case of clergy, who would the doctor make that arrangement with?
A. Well, I would hope that the clinic would have some arrangements let's say for, as you spoke in the – or someone spoke in the deposition –
Q. It wasn't me.
A. It probably wouldn't be a Catholic priest, but maybe two or three different denominations just to be on call.
Q. How would they know which denominations?
A. Well, I think that we would just have to have Protestant and whatever else. I don't know. Again, I

***

[874]

Q. But the inspector will determine whether physicians have made sufficient consulting arrangements to satisfy the requirement of 307; isn't that right?
A. That's correct.

***

[875]
A. If we receive a complaint, we generally do an investigation to go find out if that's true or not. So it would be upon that visit for the investigation that we would make that determination as to whether or not the complaint was true or not.
Q. Let me ask you something else. Does DHEC take complaints over the telephone?
A. Yes.
Q. You take anonymous complaints?
A. Yes.
Q. So if someone calls and says this facility is not clean and they don't give you their name, you'd go check it out and do an investigation of that clinic?

[876]
A. Well, it depends on the severity of it. The complaint process undergoes a lot of evaluation all the time because we are essentially a complaint-driven health licensing section now. And some of the things that we do – we may very well wait if we don't feel like it's that important because of lack of resources. We will wait until the next regular visit rather than making a special visit.
Q. What if someone calls about something a little more significant? Let's say someone calls up and they say I don't really want to tell you who I am, but I think Dr. X has dirty instruments. Would you show up and do an inspection?
A. I think that would definitely call for an investigation
Q. And that investigation can be made unannounced?
A. Oh, yes.
Q. Probably would be in that circumstance, wouldn't it?
A. Oh, yes. The only announcements we do are initial licensing inspections.

Q. And you haven't given any thought to how many investigations you might be doing given the hotly contested issue involved in these regulations, have you?
A. It's come to my mind.
Q. Might be a lot, mightn't there?
A. Could be.

***

[914]
Q. What would be the reason that an inspector would need to photocopy records?
A. First of all, let me point out that it is hardly ever done. It's very rare. The only reason that we would have need to copy a record is if – usually it would be in conjunction with a complaint, and we either could not finish the examination of the record while we were at the site and needed to take a copy back to examine it more closely in the office or if there was possibly the need for it to be used in evidence, if there was a hearing, to go ahead and take that photocopy of that record to make sure that it was not altered from the time that we would have left the clinic until we got back to the office.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

EXCERPT FROM TRIAL TESTIMONY OF
CHARLES J. WARD
JULY 17, 1998

[1063]
20 Q. Let's just do it again. Could you determine with any
21 certainty whether you were qualified?
22 A. Not with any certainty.

Plaintiffs' Exhibit 11

State of South Carolina
Department of Health and Environmental Control
Report of Induced Termination of Pregnancy

91 007706
State File Number

1. Facility Name (if not clinic or hospital, give address)
   CWMC

2. City, town, or location of pregnancy termination
   Chas

3. County of pregnancy termination
   Chas

4. Patient Identification Number
   (Do not enter patient's name)
   912665

5. Age last Birthday
   15

6. Married?
   [ ] Yes [✓] No

7. Date of Pregnancy Termination (Month, Day, Year)
   [*illegible*]

8a. Residence - State
   SC

8b. County
   Horry

8c. City, Town or Location
Murrells Inlet

8d. Inside City Limits
[✓] Yes [ ] No

8e. Zip Code
29576

9. Of Hispanic Origin?
(Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)
[ ] Yes [✓] No

10. Race
[ ] American Indian
[ ] Black
[✓] White
[ ] Other (*Specify*)_____

11. Education (Specify only highest grade completed)

Elementary/Secondary (0-12)	College (1-4 or 5+)
9	

12. Date last normal menses began (Month, Day, Year)
Jul. 6 91

13. Date of conception (Month, Day, Year)
Jul 23 91

14. Clinical Estimate of Gestation (Weeks)
7

15. Previous Pregnancies (Complete each section)

LIVE BIRTHS

15a. Now living
Number _____
[✓] None

15b. Now Dead
Number _____
[✓] None

OTHER TERMINATIONS

15c. Spontaneous
Number _____
[✓] None

15d. Induced (do not include this termination)
Number _____
[✓] None

16. TERMINATION PROCEDURES

16a. Procedure that terminated pregnancy
(check only one)

16b. Additional procedures used for this termination if any
(check all that apply)

TYPE OF TERMINATION PROCEDURES

1 [✓] ..... Suction Curettage ..... [ ] 1
2 [ ] ..... Sharp Curettage ..... [ ] 2
3 [ ] ..... Dilation and Evacuation (D&E) ..... [ ] 3
4 [ ] ..... Intra-Uterine Saline Instillation ..... [ ] 4
5 [ ] ..... Intra-Uterine Prostaglandin Instillation ..... [ ] 5
6 [ ] ..... Hysterotomy ..... [ ] 6
7 [ ] ..... Hysterectomy ..... [ ] 7
8 [ ] ..... Other (Specify_____) ..... [ ] 8
None ..... [✓] 0

17 - 18 CONSENT REQUIREMENTS
(Pursuant to Chapter 41, Title 44 of the Code of Laws of South Carolina, 1975, as amended)

17a. Was informed written consent obtained from the Patient?
[✓] Yes [ ] No

17b. If no, Informed Written Consent was not obtained due to:
(check one)
1 [ ] Medical Emergency
2 [ ] Incest
3 [ ] Not Capable/Mentally Incompetent
4 [ ] None of the Above

18a. If patient is under 17 years of age additional informed written consent obtained from:
(check one)
1 [ ] Parent
2 [ ] Legal Guardian
3 [ ] Grandparent
4 [✓] Person in Loco Parentis
5 [ ] None of the Above

Problems...
after an abortion?
MEDICAL • LEGAL • EMOTIONAL HELP
1-800-634-2224

19. Name of Attending Physician (type/print)
Richard O. Manning, M.D.

20. Name of Person Completing Report (type/print) ..... Title
C. Moore

21. Date Report completed (Month, Day, Year)
Aug. 27, 1991

For State office use only
22. Date report received
SEP. 09 1991

Plaintiffs' Exhibit 12

"S.C. Missionaries to the Unborn"

We have the sad responsibility to inform you that your neighbor Lorraine Maguire of 2215 Dawn Hill Dr. operates the state of South Carolina's largest abortion clinic. The Charleston Womens Medical Clinic at 1312 Ashley River Rd.

Lorraine personally supervised the violent brutal deaths of 3,000 helpless innocent unborn children in 1990 alone. This is according to DHEC statistics.

As women and mothers we can not understand how she can operate so grisly a business and prey on the most vunerable in our society, women in crisis and the most vunerable of all, little tiny babes that can't fight back?

You can understand Lorraines motivation however when you multiply those 3,000 deaths times $275.00, the average price to kill a child, you get a total of $875,000.000. Abortions are preformed at Lorraines clinic on tuesday, friday, and saturday for just a few hours in the morning or in the afternoon. Each porcedure only takes between 10 and 15 minutes. They line the women up and boom boom boom one ofter another. One doctor can preform as many as 30 abortions in one day.

The highest number of children killed at Lorraines clinic on one day, that we have been able to research, was August 17th 1990 when 34 children were killed. August 17th was a saturday, they close at 2pm on saturdays.

When you are faced with the grim statistics you have to face the reality that her main motivation for running a human slaughter house is GREED. Abortion is like drugs or pornography. People are going to get them, do them, and have them. Whether they are good for them or right for them or not. Woe to the ones through whom they come.

Lorriaine McGuire moved here from Greenville in 1985. She operated another clinic there. These clinics are part of a

ten clinic chain owned by two brothers Ernest and Mike Harris.

We would like to also share some information we obtained from a Tri-County Coalition for Choice meeting that four of our members infiltrated in October of 1991. Lorraine was listed on the program as one of the speakers. She never came however. The people running the meeting said she had a problem with a family member. A lawyer named Margaret Fabri spent 20 minutes explaining to the teenagers in the audiance. brought by the way as a youth group from a Luthern Church by their pastor Timothea Lewis who was also a member of the panel, how to get around the parental consent laws of our state. The last thing Ms. Fabri said was for the children not to try and remember all she said, just go to Lorraine she knows how to get around the law! We have included on the reverse of this flier a form that is filled out for abortions done in our state. The person who signed for this 15 year old girl to get an abortion was not one of her parents? The youngest child Lorraine helped preform an abortion on was 13 years old!

There are few businesses a women like Lorraine could go into that can generate nearly a million dollars a year from only 3 days a week work. Certainly not a cataring company or a florist. We feel so sorry for Lorraine Maguire and her family. The Bible clearly tells of God's judgement on people who shed innocent blood. If Cain was given a mark and lost fellowship with God for killing one innocent person, Able, what will become of Lorraine and those who participate with her in her evil trade? They have shed the blood of thousands of innocent children. Pray with us for her that she will repent!

S.C. Missionaries to the Unborn P.O. box 60593
N. Charleston, S.C. 29418
(803) 566-9675.

Plaintiffs' Exhibit 16 [Excerpt]

Guidelines for Women's Health Care was developed under the direction of the Committee on Professional Standards (1992-95):

Fredric D. Frigoletto, Jr, MD, Chairman
Leo J. Dunn, MD
Carla D. Harris, RN
Kenneth L. Noller, MD
Henry A. Thiede, MD
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Robert W. Yelverton, MD

Stanley Zinberg, MD, director of Practice Activities
Shirley A. Shelton, Associate Director, Clinical Practice

Rebecca D. Rinehart, Associate Director, Publications

Rick Johnston, Design

The information in *Guidelines for Women's Health Care* should not be viewed as a body of rigid rules. The guidelines are general and intended to be adapted to many different situations, taking into account the needs and resources particular to the locality, the institution, or the type of practice. Variations and innovations that improve the quality of patient care are to be encouraged rather than restricted. The purpose of these guidelines will be well served if they provide a firm basis on which local norms may be built.

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Defendants' Exhibit 18a [Excerpt]

ADMINISTRATIVE PROCEDURES

Personnel Policies and Procedures

NAF member facilities must provide vacation and sick-leave benefits for full-time staff members. NAF recommends an annual vacation leave of two weeks (ten days) and sick leave of one day per month (twelve days annually). Health insurance coverage is also recommended for employees of NAF member facilities.

A written job description including an outline of duties and qualifications should be available for each position. The job descriptions should be updated as duties change.

Performance appraisals should be in writing with the supervisors' and employees' signatures. Performance appraisals should be kept in the employee personnel folder along with other information pertaining to that employee. The employee has the right to review his/her personnel file upon request. The employee also has the right to an interview by his/her supervisor when requested.

The member facility should ensure there is appropriate professional liability (malpractice) coverage for the benefit and protection of the facility, its staff, and patients. Each facility should support Affirmative Action practices in staffing and advertising positions.

There must be a written and posted protocol for life-threatening medical emergencies. In addition there must be written descriptions of procedures and policies in each area of care, including:

-- nursing
-- counseling
-- abortion procedures
-- laboratory services

It is recommended that clinic hours be set considering the needs of the patients as well as the staff.

Clinic Security

Written guidelines must be available for all staff relating to nonmedical emergency procedures. These should be posted in a place appropriate for inspection by staff members.

It is recommended that a smoke and burglar alarm system be installed in each facility.

Patient Fees and Records

Each facility will have policies to accommodate low-income women. Specific financial arrangements should be made available to a minimum of ten percent of the patient load. There must be a contractual agreement between the woman and the facility outlining the payment plan and the collection policies. Collection policies must be in compliance with federal guidelines. The patient's record must not be released without the consent (preferably in writing) of the patient.

Confidentiality

Every woman has the right to expect her privacy will be respected and confidentiality of her records protected. Since most states do not have legislation protecting the confidentiality of medical records, care should be taken when making a notation on her record (particularly counseling notes). In addition, if a member of the facility receives a subpoena for a woman's records, action must be taken to prohibit the release of the records without the woman's consent.

Additional suggestions to protect confidentiality are:

-- keep all doors locked in accordance with fire code except the door where the patients enter;

-- before discarding, shred all waste paper that may have a patient's name or information;

-- each night, lock all information with patients' names, including appointment books and daily logs;
-- keep any and all paperwork with identifying names and numbers in desks – not unattended in full view of others in the clinic; and,
-- never disclose to a telephone caller information about a patient that may be in the facility, rather state that if that person is in the facility you will deliver a message to have the patient return the call.

Minors

Minors should be served in the same manner as other women, keeping in mind possible restrictions upon hospital admission without parental consent. If hospitals will not admit without parental consent, minors should be made aware that, in case of emergency, it may not be possible to maintain confidentiality.

Administrative Supervision

While direct professional supervision of physicians, nurses, and counselors is the responsibility of the senior professional in each area, the chief administrative officer responsible for the general supervision of clinic functions should assure that personnel policies and procedures are formulated, distributed, and observed in an equitable manner.

In a professional organization such as an abortion service, this includes the arrangements for continuing training in the form of individual supervision, in-service education programs, and continuing education opportunities for all professional and paraprofessional staff members.

Individual agencies are responsible for knowledge of current local nurse practice acts. Agencies may not require nurses to practice outside the legal limits of local nurse practice acts.

Agencies are also responsible for knowledge of the current state of licensure and professional liability insurance for physicians engaged in medical practice within the facility or those acting in its name.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

DECLARATION OF TERRY BUFFKIN, M.D.
[Excerpt]

21. Third, I am extremely concerned about the fact that the Regulation permits DHEC employees to access, copy and remove our patients' records without prior notice, yet does not require DHEC to maintain those records (and the information contained in them) in strict confidence. This provision is inconsistent with safeguarding our patients' privacy, health and welfare. Indeed, it absolutely prevents me from ensuring the privacy of my patients' identities and medical conditions. Once DHEC removes a patient record from our office, I would have no control over who has access to that record. This would constitute a substantial breach of our patients' confidentiality, and it may dissuade some of them from seeking care at our facility or any other licensed facility in the State.

22. The Regulation also threatens our patients' confidentiality and well-being by requiring them to provide their husbands' names for our medical records. It is my opinion that, for a variety of reasons, many patients will not want to give us this information, and may therefore provide us false information about their identities.

23. Discouraging women from seeking health care from their physicians and encouraging them to provide false information to their physicians threaten women's health.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

DECLARATION OF WILLIAM LYNN, M.D.
[Excerpt]

1 I also provided abortion services for many years in my office in Beaufort. Subsequent to the trial in this case, my landlord decided not to renew my lease. At that time, I decided that it would not be economically feasible for me to reopen my Beaufort practice in another location. This decision was based on a number of factors, including the costs of moving the practice, and the costs of complying with the Regulation.

***

21. Second, the Regulation permits the Department of Health and Environmental Control ("DHEC") to inspect, copy and remove patients' records from my office. This causes a substantial breach of the confidential relationship that I maintain with my patients. In my opinion, many of my patients will be reluctant to get abortions if their confidentiality cannot be maintained. My patients are already very concerned about confidentiality and they often ask me numerous questions about whether their identity will be disclosed to anyone outside of our office. I am concerned that if the Regulation takes effect, some of my patients will attempt to self-abort or to obtain abortions from unlicensed persons, or will be forced to travel to other states in an attempt to maintain their confidentiality.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

[CAPTION OMITTED IN PRINTING]

DECLARATION OF GARY BOYLE, M.D.
[Excerpt]

23. Third, I am extremely disturbed by the provision in the regulation that permits DHEC to inspect, remove and copy patient records. Confidentiality is critical to abortion patients, and we work very hard to maintain that confidentiality. If this provision goes into effect, I believe that we will have to inform our patients that their records may be obtained by DHEC. This will surely frighten and anger many of our patients. It may also force patients to delay their abortions until they can go to another state where their confidentiality will be maintained or to attempt to self-abort. Either alternative poses very serious risks to the patients' health and well-being.

Supreme Court, U.S.
FILED
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No. 02-1235

IN THE

Supreme Court of the United States

GREENVILLE WOMEN'S CLINIC and WILLIAM LYNN, M.D., on behalf of themselves and their patients seeking abortions,

Petitioners,

v.

COMMISSIONER OF THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL, GOVERNOR OF THE STATE OF SOUTH CAROLINA, and HENRY McMASTER, in his official capacity as Attorney General of the State of South Carolina,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF IN OPPOSITION

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INTRODUCTION

This petition arises from the Petitioners' constitutional challenge to regulations governing abortion facilities in South Carolina and marks the second time the Petitioners have come before the Court seeking a writ of certiorari. Petitioners filed this action in June 1996. Following a bench trial, the District Court issued on February 5, 1999, an order permanently enjoining enforcement of the regulations, holding that they violated the Due Process and Equal Protection Clauses of the United States Constitution. *Greenville Women's Clinic v. Bryant*, 66 F. Supp. 2d 691, 744-45 (D.S.C. 1999). The Fourth Circuit Court of Appeals reversed, *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 179 (4th Cir. 2000) (*Bryant I*), and this Court denied the petition for writ of certiorari. 531 U.S. 1191 (2001).

Following remand from the Fourth Circuit, the District Court received briefs on four additional claims that the District Court's February 5, 1999 Order had not addressed. In an Order dated August 31, 2001, the District Court held that Regulation 61-12 did not violate the United States Constitution regarding alleged vagueness, alleged delegation of veto power over medical facility licensing to third parties, and the alleged violation of the Establishment Clause. App. 54-58. Although the District Court did hold that Regulation 61-12 violated the petitioners' constitutional right to informational privacy, A. 58-59, it also found that this portion of the Regulation was severable from the remaining portions of the Regulation. App. 59.

The Petitioners appealed the District Court's order relating to all claims except informational privacy, and the Respondents cross-appealed on the informational privacy issue. The Fourth Circuit affirmed those rulings of the District Court that upheld the regulations, and reversed the District Court's ruling regarding informational privacy, thus issuing an opinion that effectively upheld the Regulation in its entirety. *Greenville Women's Clinic v. Commissioner, South Carolina Department of Health and Environmental*

Control, 306 F.3d 1 (4th Cir. 2002) (*Bryant II*). Petitioners then filed the petition for a writ of certiorari that is now before the Court. In it, they urge the Court to grant certiorari on each of the four constitutional issues addressed by the Fourth Circuit in *Bryant II*. Again, those issues involve: (1) the alleged constitutional right to informational privacy; (2) the Establishment Clause; (3) the non-delegation doctrine; and (4) a vagueness challenge. For the reasons that follow, the State respectfully requests that the Court deny the petition.

RESPONSES TO ARGUMENTS ADVANCED BY PETITIONERS

I. GWC first argues that this Court should grant certiorari on the issue of whether Section 102(F) of Regulation 61-12 violates the constitutional right to informational privacy that Petitioners' allege this Court recognized in *Whalen v. Roe*, 429 U.S. 589 (1977). The critical issue in this case, however, and the critical issue in the context of subsequent similar cases involving similar regulations, is whether *Whalen* even applies in the context of facial challenges to the recordkeeping and reporting requirements of abortion providers. The State submits that a *Whalen* claim will not lie in that context, having been displaced by *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 878 (1992). Critically then, since Petitioners' *Casey* claim was the subject of the first Fourth Circuit opinion in this case, and because this Court denied the petition for a writ of certiorari in that case, Petitioners' informational privacy claim is not now properly before this Court.[1]

---

1. The State distinguishes between facial challenges and as-applied challenges under *Whalen* in the context of abortion regulations because it is possible that although an abortion regulation governing medical records does not impose an undue burden on a woman's right to choose, information obtained pursuant to the regulation could theoretically be actually disclosed in a manner inconsistent with the constitutional right to informational privacy, assuming that there is such a right. But, as (Cont'd)

In *Casey*, the joint opinion of Justices O'Connor, Kennedy, and Souter, stated point blank that "[r]egulations designed to foster the health of a woman seeking an abortion are valid if they do not constitute an undue burden."[2] 505 U.S. at 878. Applying that standard to the recordkeeping and reporting requirements of the Pennsylvania statute at issue in *Casey*, the joint opinion concluded that those requirements were constitutional because "[t]he collection of information with respect to actual patients is a vital element of medical research," and the Court did not find "that the requirements impose a substantial obstacle to a woman's choice."[3] *Id.* at 900-01. The opinion expressly considered patient confidentiality in making this determination. *See Casey*, 505 U.S. at 900 (joint opinion) (factoring into the analysis of the recordkeeping provisions the fact that "the identity of each woman who has had an abortion remains confidential").

In the previous appeal in this case, the Fourth Circuit ruled that, under the undue burden standard articulated in *Casey*, Regulation 61-12 passed constitutional muster

---

(Cont'd)
explained in the body of this response, facial due process challenges to abortion regulations are properly analyzed under the undue burden standard, not the strict scrutiny standard for which Petitioners advocate.

2. The joint opinion made this statement in Part IV, in which the authors were speaking only for themselves in adopting the undue burden standard. In subsequent cases from this Court, however, a majority has applied that standard. *See Stenberg v. Carhart*, 530 U.S. 914, 921 (2000) (setting forth the standards governing challenges to abortion regulations "in the language of the joint opinion in *Casey*" and "apply[ing] them to the circumstances of th[e] case"). Thus, insofar as the Due Process Clause is concerned, the undue burden standard currently governs challenges to regulations that impact abortion.

3. Justice Stevens joined this portion of the Court's opinion, and Chief Justice Rehnquist and Justices White, Scalia, and Thomas concurred in the judgment. *See Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 911 (1992) (Stevens, J. concurring in part and dissenting in part); *id.* at 944 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part).

notwithstanding the recordkeeping and reporting requirements (and actually cited *Whalen* in the relevant passage):

> Nor does it unduly burden a woman's right to decide to obtain an abortion that DHEC officials may inspect abortion clinics and copy necessary documents. Such inspections ensure compliance with health care standards, an end which the copying provision also furthers. *See Danforth*, 128 U.S. at 79, 81 (noting that a statute that allowed medical records to "be inspected and health data acquired by local, state, or national public health officers" did not have a "legally significant impact or consequence on the abortion decision or on the physician-patient relationship" (internal quotation marks omitted)). *This is particularly so in view of the Regulation's requirement that "all records shall be treated as confidential," thereby respecting patients' privacy. See id.* at 80 (noting that proper respect for patient's confidentiality was a factor in upholding reporting requirement); *cf. Whalen v. Roe*, 429 U.S. 589, 602 & n.29 (1977) ("disclosures of private medical information to . . . public health agencies are often an essential part of modern medical practice even when the disclosure may reflect unfavorably on the character of the patient").

Bryant I, 222 F.3d at 171-72 (emphasis added). This Court denied the petition for a writ of certiorari in *Bryant I*. 531 U.S. 1191 (2001). Thus, the Due Process challenge to the recordkeeping and reporting requirements of Regulation 61-12 is simply water under the bridge at this point, and Petitioners' informational privacy claim is therefore not properly before the Court. *See Agostini v. Felton*, 521 U.S. 203, 236 (1997) ("Under [the law of the case] doctrine, a court

should not reopen issues decided in earlier stages of the same litigation."). [4]

Pausing to respond directly to arguments made by Petitioners, the State begins with Petitioners' suggestion in section IB that there is a circuit split concerning the proper resolution of informational privacy claims. *See* Petition for Certiorari at 11. The State disagrees that there is a circuit split on the relevant question presented by this appeal. Again, the informational privacy claim at issue is being asserted in the context of a facial Due Process challenge to recordkeeping and reporting requirements for abortion providers. This Court has established that such challenges are to be analyzed under the undue burden standard, and there is simply no disagreement among the Circuits about that basic fact.

Even assuming, as Petitioners' suggest, that there is a circuit split about how to resolve general informational privacy claims under *Whalen*, this case does not implicate that split because this case arises in the specific context of abortion regulations. Of all the cases cited by the Petitioners to establish a Circuit split on the *Whalen* issue, only one involved abortion regulations. *Cf. Planned Parenthood of Southern Arizona v. Lawall*, 307 F.3d 783 (9th Cir. 2002) (addressing a *Whalen* claim in the context of an abortion statute) *with Denius v. Dunlap*, 209 F.3d 944 (7th Cir. 2000) (discussing *Whalen* in the context of requirement that confidential information, including financial information and attorney-client communications, be disclosed prior to employment in the public sector); *American Fed. of Gov't Employees v. HUD*, 118 F.3d 786 (D.C. Cir. 1997) (discussing *Whalen* in the context of order requiring certain federal employees to respond to a questionnaire about their use of illegal drugs and their financial history); *Alexander v. Peffer*,

4. In fact, as evidence that Petitioners' *Whalen* claim is merely an attempt to recycle their *Casey* claim it is noteworthy that they cite *Casey* twice in arguing that the patients' informational privacy right has been compromised, *see* Petition for Certiorari at 17, 20, and also cite several of this Court's pre-*Casey* abortion cases.

993 F.2d 1348 (8th Cir. 1993) (discussing *Whalen* claim in the context of allegations that disclosures had been made on talk radio that appellant failed to qualify for a position as a police officer); *James v. City of Douglas*, 941 F.2d 1539 (11th Cir. 1991) (discussing *Whalen* in the context of claims that arose from a police department's mishandling of a videotape containing sexually explicit activity); *Walls v. City of Petersburg*, 895 F.2d 188 (4th Cir. 1990) (discussing *Whalen* in the context of a background questionnaire required for public employment which asked about homosexual relations; marriages, divorces, and children; arrests or convictions of family members; and financial information)[5]; *Daury v. Smith*, 842 F.2d 9 (1st Cir. 1988) (discussing *Whalen* in the context of a requirement imposed by a public school that a certain person receive psychiatric treatment before returning to work as a teacher); *Barry v. City of New York*, 712 F.2d 1554 (2d Cir. 1983) (discussing *Whalen* in the context of public inspection provisions of city financial disclosure law); *Denver Policeman's Protective Ass'n v. Lichtenstein*, 660 F.2d 432 (10th Cir. 1981) (discussing *Whalen* in the context of an order compelling discovery of personnel and staff inspection bureau files of certain police officers); *J.P. v. DeSanti*, 653 F.2d 1080 (6th Cir. 1981) (discussing *Whalen* in the context of disclosure of juvenile court records); *United States v. Westinghouse Elec. Co.*, 638 F.2d 570 (3d Cir. 1980) (discussing *Whalen* in the context of a subpoena duces tecum requiring company to disclose employees' medical records); *Plante v. Gonzalez*, 575 F.2d 1119 (5th Cir. 1978) (discussing *Whalen* claim in the context of a state constitutional amendment requiring financial disclosure from certain elected officials).

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5. The *Walls* Court analysis of the children issue did not directly discuss abortion but did conclude that "any details that are not part of the public record concerning . . . the birth of children are private and thus protected." *Walls*, 895 F.2d at 193. *Walls* preceded *Casey*, however, and so the constitutional protection afforded the woman's decision to abort is now governed by *Casey*. Thus, the *Walls* Court had no occasion to decide whether *Whalen* would still be applicable to abortion issues in a post-*Casey* world.

Although the *Lawall* case discussed a *Whalen* claim in the context of abortion regulations, there is no indication that the Ninth Circuit was presented with the argument that in the specific context of a facial challenge to recordkeeping provisions of an abortion regulation *Casey* displaced *Whalen* with regard to informational privacy claims ("the displacement argument"). The *Lawall* Court upheld the validity of the Arizona statute there at issue under both *Casey* and *Whalen*, concluding that it satisfied the undue burden test and did not infringe upon the right to informational privacy. With regard to the latter claim, the Court, rather than applying the strict scrutiny test for which the Petitioners in this case advocate, held that it was the State's burden "to demonstrate that its use of the information would advance a legitimate state interest and that its actions are narrowly tailored to meet the legitimate interest." *Lawall*, 307 F.3d at 790. To the extent that this articulation of the test to be applied to informational privacy claims in the context of abortion regulations differs from the undue burden test articulated in *Casey*, the State notes again that the Ninth Circuit was apparently not asked to address any potential problem with applying *Whalen* instead of *Casey*.[6] Furthermore, *Lawall* is consistent with the

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6. Indeed, Petitioners may well argue that the displacement argument set out above was not presented below and is therefore waived. There are at least three responses to that potential argument, the first being that if this Court agrees that the State waived the ability to contest the critical issue of the appropriate legal standard under which to analyze the informational privacy claims being asserted in this case, there is simply no point in this Court expending its resources on the issue and certiorari should be denied. Second, while the displacement argument certainly was not developed below with as much precision as it could have been, the State consistently argued that the recordkeeping provisions of Regulation 61-12 did not violate anyone's constitutional right to informational privacy and relied primarily on *Casey* and on the Fourth Circuit's opinion in *Bryant I*, in which the court held that the recordkeeping requirements satisfied *Casey*. *See* Brief of Appellees/Cross-Appellants at 41-42. Third, it is not even clear that the State could have pressed the displacement argument with much vigor in the courts below because, at least at a general level, *Whalen* would appear to govern the informational privacy claims in this case, and, as this Court has made (Cont'd)

Bryant II majority opinion to the extent that neither case held that strict scrutiny was applicable.

The Petitioners also allege, under section IA of their petition, that "South Carolina law undisputedly authorizes disclosure of abortion patients' medical records in licensing proceedings." Petitioners allege that South Carolina does not go far enough to ensure the confidentiality of abortion patients' records and that its failure to do so will significantly impact a woman's abortion decision. But confidentiality is a factor in the *Casey* analysis, which was the subject of *Bryant I*, and therefore is not properly before the Court. *Cf. Casey*, 505 U.S. at 900 (joint opinion) (factoring into the analysis of the recordkeeping provisions the fact that "the identity of each woman who has had an abortion remains confidential") *with Bryant I*, 222 F.3d at 171-72 (upholding recordkeeping and reporting requirements of Regulation 61-12 because the Regulation dictates that "all records shall be treated as confidential, thereby respecting patients' privacy" (internal quotation marks omitted)).

And finally, in Section IC, Petitioners argue that if the *Bryant II* majority had applied a proper *Whalen* analysis to the recordkeeping provisions at issue, the court would have come out differently. Again, the State contends that *Casey* sets forth the proper standard in this case and that that analysis was properly conducted in *Bryant I* and is now final. To the extent that Petitioners chastize the *Bryant II* majority for allegedly not following to the Fourth Circuit's own precedent in *Walls*, which had interpreted *Whalen* to require a compelling governmental interest to override the

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(Cont'd)
clear, "other courts should [not] conclude [this Court's] more recent cases have, by implication, overruled an earlier precedent," but should apply the precedent that apparently governs "leaving to this Court the prerogative of overruling its own decisions." *Agostini v. Felton*, 521 U.S. 203, 237 (1997). Thus, if the Court grants certiorari on the informational privacy issue, the State should be allowed to present the displacement argument.

constitutional right to informational privacy, Petitioners' *Whalen* claim can be seen for precisely what it is: an attempt to return the Court to the pre-*Casey* days in which courts had erroneously interpreted *Roe* and its progeny to require strict scrutiny of a state's attempts to regulate abortion. *See Casey*, 505 U.S. at 871 (joint opinion) (expressly rejecting the application of strict scrutiny to regulations impacting abortion).[7] The State respectfully submits that the Court should decline this invitation.

In sum, this Court has declared that recordkeeping requirements in the context of abortion regulations are subject not to strict scrutiny but to the undue burden standard. There is no split in the circuits on this issue and, specifically, there is no split on how that holding affects the applicability of *Whalen* in the context of abortion regulations. Petitioners' attempt to craft a *Whalen* claim in the instant case is merely an attempted end-run around *Casey*. The *Casey* challenge to this Regulation has already run its course in the federal courts, having been the subject of a previously denied certiorari petition. To the extent that the appropriate level of confidentiality required by the Constitution to be afforded to abortion regulations is an important question of federal constitutional law, this Court has already resolved it: the undue burden standard applies. The State requests that the Court deny certiorari on the informational privacy claim.[8]

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7. Furthermore, it should be unsurprising that the *Bryant II* majority did not require the State to prove a compelling interest in this case, as the Fourth Circuit had done in *Walls*. This case involves regulations that impact abortion, and the State simply does not need a compelling interest to enact recordkeeping provisions in that context. It must only devise regulations that do not impose an undue burden on the woman's right to choose.

8. The State has made no attempt to this point to defend the analytical approach of the *Bryant II* majority, choosing instead to continue pressing the argument that *Bryant I* resolved this issue. This choice should not be construed as an admission that the *Bryant II* majority erred in its *Whalen* analysis in any respect. Should the Court grant a writ of certiorari on the *Whalen* issue, the State is fully prepared to defend the

(Cont'd)

II. Petitioners next argue that this Court should grant certiorari to review the Fourth Circuit's conclusion that § 307 of the Regulation does not violate the Establishment Clause. Section 307, entitled "Consultation," provides that

> Arrangements shall be made for consultation or referral services in the specialties of obstetrics/gynecology, anesthesiology, surgery, psychiatry, psychology, clinical pathology and pathology, clergy, and social services, as well as any other indicated field, to be available as needed.

Petitioners' argue that this Court should grant certiorari on the Establishment Clause question based upon three alleged errors in the *Bryant II* majority opinion:

> First, the majority erroneously applied the *Salerno* standard to this claim, despite the fact

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majority opinion in *Bryant II*. Specifically, even assuming that a *Whalen* claim will lie in the context of this case, the *Bryant II* majority correctly concluded that the regulation adequately protected the privacy of medical patients. Petitioners' entire argument rests upon what they see as the potential for disclosure in licensing proceedings. But this Court explained in *Whalen* itself that "the remote possibility that judicial supervision of the evidentiary use of particular items of stored information will provide inadequate protection against unwarranted disclosures is surely not a sufficient reason for invalidating the . . . patient-identification program." *Whalen*, 429 U.S. at 601-02; *cf. Hodge v. Jones*, 31 F.3d 157, 166 (4th Cir. 1994) ("The tangential possibility of public disclosure of [private information] through such theoretical means as negligent or improperly-motivated state employees or fortuitous computer hackers, cannot by itself implicate a constitutional privacy right."). Furthermore, Petitioners overlook the fact that Section 402 declares that "[a]ll records shall be treated as confidential and shall be stored in a safe location." A. 103. Also, Section 44-7-310 of the South Carolina Code provides that "[i]nformation received . . . through inspection or otherwise which does not appear on the face of the [facility's] license *may not be disclosed publicly in a manner as to identify individuals or facilities*" except in a proceeding regarding licensing. That statutory statement is unequivocal: information that would identify any individual may *not* be publicly disclosed. As discussed above, to the extent there is an exception for licensing proceedings, this exception is "surely not a sufficient reason" for finding that Regulation 61-12 inadequately protects patient privacy. *See Whalen, supra* this footnote.

> that this Court analyzes facial Establishment Clause challenges under a less onerous standard[.] Second, the majority's construction of the [Consultation Provision] violates principles of statutory construction and federalism. Finally, the [Consultation Provision], as interpreted by the State, compels abortion providers to support and participate in religion.

Petition for Writ of Certiorari 21 (citations omitted).

In support of their first contention, i.e. that this Court analyzes facial Establishment Clause challenges under a less onerous standard than the no-set-of-circumstances test articulated in *United States v. Salerno*, 481 U.S. 739, 745 (1987), Petitioners cite *Santa Fe Ind. Sch. Dist. v. Doe*, 530 U.S. 290, 313-14 (2000). To the extent that *Santa Fe* can properly be considered to have modified the *Salerno* test, it only did so, if at all, in a limited set of circumstances not applicable to the present case. A brief review of *Santa Fe* will illustrate the point.

Santa Fe involved an Establishment Clause challenge to a school board policy permitting a school chaplain to deliver a prayer over the public address system before each varsity football game for the entire season. *See id.* at 294. The Court affirmed the judgment of the United States Court of Appeals for the Fifth Circuit striking down the policy. *See id.* at 317. The dissent strenuously objected that under the *Salerno* test there was some set of circumstances under which the policy could operate in accord with the Constitution, and that the policy should therefore be upheld, pending later challenge by an appropriately pled challenge to the policy as applied. *See Santa Fe*, 530 U.S. at 318, 326 (Rehnquist, C.J., dissenting). The majority responded to this argument, which had been pressed by the school district, by stating that this Court's

> Establishment Clause cases involving facial challenges . . . have not focused solely on the

> possible applications of the statute, but rather have considered whether the statute has an unconstitutional purpose. . . . [A]s in previous cases involving facial challenges on Establishment Clause grounds, we assess the constitutionality of an enactment by reference to the three factors articulated in *Lemon v. Kurtzman*, . . . which guides "the general nature of our inquiry in this area[.]" Under the *Lemon* standard, a court must invalidate a statute if it lacks "a secular legislative purpose." It is therefore proper, as part of this facial challenge, for us to examine the purpose of the . . . policy.

Id. at 314.

This passage can be read two separate ways. It can be read to suggest that the only relevant inquiry in a facial Establishment Clause challenge is into the statute's purpose (e.g., "Our Establishment Clause cases involving facial challenges . . . have not focused solely on the possible applications of the statute, but rather have considered whether the statute has an unconstitutional purpose."). If this reading is correct, the *Bryant II* majority was unquestionably correct in its ruling below that the Consultation Provision did not on its face contravene the Constitution. If the inquiry on a facial challenge is limited to "whether the statute has an unconstitutional purpose," even the dissent in *Bryant II* should have found the provision to be facially constitutional, as the dissent found that "[w]ithout more evidence of a religious purpose, the Consultation Provision survives the first prong of the *Lemon* test." A. 39-40 (*Bryant II*, (King, J. dissenting)).

To the extent, however, that the quoted passage from *Santa Fe* may be read to allow the Court to consider the other factors of the applicable Establishment Clause analysis in the context of a facial challenge, the case does not represent an overhaul of the *Salerno* standard. The policy at issue in *Santa Fe* was found to have been motivated by an

impermissible purpose, i.e. to advance prayer. Official enactments motivated by such a constitutionally impermissible purpose are per se violations of the Constitution and it may not make sense in the context of a challenge to an enactment so motivated to ask whether there might be some circumstances under which the enactment may nonetheless operate in a constitutional manner, i.e. without the effect of advancing or inhibiting religion. The *Santa Fe* Court seemed to recognize this very point by suggesting that the constitutional violation in that case was "inevitable." *Santa Fe*, 530 U.S. at 316 ("[T]he simple enactment of this policy, with the purpose and perception of school endorsement of student prayer, was a constitutional violation. We need not wait for the inevitable to confirm and magnify the constitutional injury."). Where an ensuing constitutional violation is certain, it makes little sense as a matter of judicial economy to send the case back and await the inevitable. Thus, *Santa Fe* is perhaps best read, not as rendering *Salerno* a jurisprudential remnant of a forgotten age, but as an indication from the Court that it will not apply *Salerno* when the very enactment of the policy, statute, or regulation was a per se violation of the Constitution or when constitutional injury will inevitably follow from its enactment.[9] Neither of these scenarios presents itself here.

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9. This possible reading represents a best-case scenario for the Petitioners. The other possible reading of *Santa Fe* is that it does not affect the *Salerno* analysis at all, because, as the Court in *Santa Fe* was quite clear about, the constitutional violation in that case had already occurred. Specifically, since the policy was found to be motivated by the impermissible purpose of advancing religion through compulsory prayer, the constitutional violation occurred at the moment the policy was enacted. *See, e.g. Santa Fe*, 530 U.S. at 314 (stating that the Constitution is offended by "the mere passage by the District of a policy that has the purpose and perception of government establishment of religion."). Under this view of the case, the Court's discussion of *Salerno* may well have been dictum. Since the constitutional violation occurred at the moment of the policy's passage, there was, by definition, no set of circumstances under which the policy could have avoided constitutional difficulties. That fact would distinguish the case from *Salerno*, but would in no way detract from the *Salerno* analysis.

To explain why not, the State will pause briefly to incorporate Petitioners' second assignment of error on the Establishment Clause issue, i.e. that the *Bryant II* majority erred in its construction of the Regulation. Petitioners argue that "DHEC has interpreted [Section 307] to require that abortion providers establish ongoing consulting agreements with clergy," Pet. for Cert. 21, and that the *Bryant II* majority erred in holding otherwise. Putting aside the obvious problems with Petitioners' characterization of the ad hoc testimony of one individual as an official agency interpretation,[10] and assuming arguendo that the Regulation does require such "ongoing consulting agreements," there is no per se constitutional violation and no constitutional injury certain to follow from its implementation. Rather, the State submits that if *Bowen v. Kendrick*, 487 U.S. 589 (1988) is still good law, and there can be little doubt that it is, *see Agostini v. Felton*, 521 U.S. 203, 233-35 (1997) (citing *Bowen* several times in explanation of how to determine whether a government enactment results in excessive entanglement between church and state), the Consultation Provision is most assuredly constitutional. At the very least, in light of *Bowen*, the enactment of the Provision was not a per se constitutional violation or an official act from which a constitutional violation is certain to flow.

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10. The Petitioners essentially attempt to build their Establishment Clause case on the testimony of a single government employee (George Moore), contending that a few of the answers he gave to a couple of questions during the course of this litigation is the equivalent of an agency interpretation of its own regulation. The majority opinion in *Bryant II*, the Petitioners contend, gave inadequate deference to his statements. This proposition cannot be admitted. The statements referred to are not an official agency interpretation. The federal courts have recognized that a position taken in litigation is not the equivalent of a considered and reasoned judgment of the agency. A. 38, n.14 (*Bryant II* (King, J. dissenting)). As even the dissenting opinion in *Bryant II* recognized, Mr. Moore's statement is more fairly characterized, not as such a judgment, but as an ad hoc statement made by a single member of the agency during this litigation. *See id.* The State is confident that the *Bryant II* majority opinion gave this testimony its appropriate weight in resolving the Establishment Clause challenge.

Bowen v. Kendrick, 487 U.S. 589 (1988) involved both a facial and an as-applied Establishment Clause challenge to the federal Adolescent Family Life Act ("AFLA"). Congress passed AFLA in an attempt to address "the severe adverse health, social, and economic consequences that often follow pregnancy and childbirth among unmarried adolescents." *Id.* at 593 (internal quotation marks omitted). To this end, AFLA established a scheme for awarding grants "to public or nonprofit private organizations or agencies for services and research in the area of premarital adolescent sexual relations and pregnancy." *Id.* (internal quotation marks omitted). Grant applicants were statutorily required, in designing programs to address the concerns of Congress, to "make use of support systems such as . . . family members, friends, religious and charitable organizations, and voluntary associations." *Id.* at 596 (internal quotation marks omitted). Applicants were required to describe in their submissions the ways in which they planned to "involve the families of adolescents, and involve religious and charitable organizations, voluntary associations, and other groups in the private sector as well as services provided by publicly sponsored initiatives." *Id.* (internal quotation marks and brackets omitted). No one disputed that, not surprisingly, "a number of grantees or subgrantees were organizations with institutional ties to religious denominations." *Id.* at 597.

After concluding that the "purpose" prong of an Establishment Clause inquiry was not at issue, the *Bowen* Court began its discussion of the "effects" prong by noting a couple of important facts. It noted, inter alia, that "[t]here is no requirement in the Act that grantees be affiliated with any religious denomination, although the Act clearly does not rule out grants to religious organizations." *Bowen*, 487 U.S. at 604. Furthermore, although it was

> [c]ertainly . . . true that a substantial part of the services listed as 'necessary services' under the Act involve some sort of education or counseling,

> . . . there is nothing inherently religious about these activities and appellees do not contend that, by themselves, the AFLA's 'necessary services' somehow have the primary effect of advancing religion.

Id. at 605 (citations omitted). The Court observed then, that

> it can be argued that the AFLA advances religion by expressly recognizing that 'religious organizations have a role to play' in addressing the problems associated with teenage sexuality. In this view, even if no religious institution receives aid or funding pursuant to the AFLA, the statute is invalid under the Establishment Clause because, among other things, it expressly enlists the involvement of religiously affiliated organizations in the federally subsidized programs, it endorses religious solutions to the problems addressed by the Act, or it creates symbolic ties between church and state.

Id. at 605-06 (citation omitted).[11]

The Court rejected this argument, reasoning that the provisions of the Act designed to ensure the involvement of religiously affiliated organizations

> . . . reflect at most Congress' considered judgment that religious organizations can help solve the problems to which the AFLA is addressed. Nothing in our previous cases

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11. The Court also noted that "[s]econdly, it can be argued that the AFLA is invalid on its face because it allows religiously affiliated organizations to participate as grantees or subgrantees in AFLA programs." This part of the Court's discussion has no bearing on the instant case because the potential argument was premised on the fact that the Act "authorizes direct federal funding of religious organizations." *Bowen*, 487 U.S. at 606. No funds change hands under the Regulation being challenged in the instant case.

> prevents Congress from making such a judgment or from recognizing the important part that religion or religious organizations may play in resolving certain secular problems. Particularly when, as Congress found, "prevention of adolescent sexual activity and adolescent pregnancy depends primarily upon developing strong family values and close family ties," it seems quite sensible for Congress to recognize that religious organizations can influence values and can have some influence on family life, including parents' relations with their adolescent children. To the extent that this congressional recognition has any effect of advancing religion, the effect is at most "incidental and remote." In addition, although the AFLA does require potential grantees to describe how they will involve religious organizations in the provision of services under the Act, it also requires grantees to describe the involvement of "charitable organizations, voluntary associations, and other groups in the private sector[.]" In our view, this reflects the statute's successful maintenance of "a course of neutrality among religions, and between religion and non-religion[.]"

Id. at 606-07 (citations omitted).

The parallels between the statute at issue in *Bowen* and the Regulation at issue in this case are striking. The inclusion of "clergy" in the laundry list of organizations with whom abortion providers must have referral and consultation arrangements merely reflects the State's considered judgment that the religious perspective has something legitimate to contribute to preserving the psychological health of a woman facing a decision that this Court has described as "more than a philosophical exercise." *Casey*, 505 U.S. at 852. Nothing in this Court's previous cases

prevents the State from making this determination. Particularly when one considers the fact that to many female believers the potential impact of the abortion transcends secular psychology and may well have ramifications for her "immortal soul," *see Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 781 (Stevens, J., concurring), it seems quite sensible for the State to recognize that religious counselors may well have a great deal to contribute to serving the State's secular purpose of promoting and preserving the health of its women citizens. To the extent that the Consultation Provision has any effect of advancing religion it is at most incidental and remote. Furthermore, much like the challenged provisions in *Bowen*, the Consultation Provision requires abortion providers to have relationships with counselors in the private sector (i.e. psychologists and psychiatrists) and with other social services. By including secular and religious counselors in § 307, the State did little more than chart "a course of neutrality among religions, and between religion and non-religion[.]" *Bowen*, 487 U.S. at 607. *Bowen* dictates that the Consultation Provision of Regulation 61-12 is constitutional. The State respectfully requests that the Court deny certiorari on this issue.

III. GWC next argues that this Court should grant certiorari on the question of whether Regulation 61-12 effects a standardless delegation of licensing authority to area hospitals. To quote from the Petition, Petitioners argue that

> [T]he Regulation requires, as a prerequisite for licensing, that physicians who provide abortions either have admitting privileges at a local hospital that has successfully sought state certification as an abortion provider, or have a documented transfer arrangement with such a hospital and a written consulting agreement with a physician who has admitting privileges at such a hospital. In either case, the physician must obtain the cooperation of the local hospital, and

> in either case, the hospital must itself have successfully attempted to become certified by the State as an abortion provider. Nothing in the Regulation or South Carolina law prevents local hospitals from declining to apply for abortion certification or from denying a physician admitting privileges on the basis of the hospitals' opposition to abortion. Thus, the Regulation essentially grants hospitals the authority to prevent licensing of abortion facilities for virtually any reason, including opposition to abortion. Such a delegation of veto power over abortion providers' licenses violates Plaintiffs' right to due process.

Petition for Certiorari 26 (citation omitted).

Petitioners cite, inter alia, *Causeway Med. Suite v. Ieyoub*, 109 F.3d 1096 (5th Cir. 1997) as support for their argument, but Petitioners' explanation of *Causeway* is a significant mischaracterization of that case. Specifically, Petitioners' parenthetical following the cite to *Causeway* characterizes the case as "striking down a delegation of standardless veto power over minors' abortions to judges, and explaining that 'this discretion itself, and not the exercise of it,' is unconstitutional." Petition for Certiorari 28. Although the quoted language does in fact come from the *Causeway* opinion, the quote is taken so out of context as to render it meaningless.

Causeway involved a challenge to a Louisiana statute requiring parental consent before a minor could obtain an abortion. After this Court decided *Bellotti v. Baird*, 443 U.S. 622 (1979), Louisiana amended the statute to comply with the Court's opinion. Specifically, so far as is relevant to this case, Louisiana added a bypass procedure by which the state courts were required to allow a minor to obtain an abortion if she could prove that she was sufficiently mature to make the decision, or if the court otherwise determined that an

abortion would be in the minor's best interest. The relevant language from *Bellotti* that Louisiana sought to track declared that

> If [the minor] satisfies the court that she is mature and well enough informed to make intelligently the abortion decision on her own, the court *must* authorize her to act without parental consultation or consent. If she fails to satisfy the court that she is competent to make this decision independently, she must be permitted to show that an abortion nevertheless would be in her best interests. If the court is persuaded that it is, the court *must* authorize the abortion.

Causeway, 109 F.3d at 1099 (citing *Bellotti*, 443 U.S. at 647-48) (emphasis in *Causeway*)).

After a couple of intervening amendments in the years between 1980 and 1995 that left the statute in compliance with *Bellotti*'s mandate that abortions for minors *must* be authorized in the above described circumstances, the Louisiana Legislature amended the statute in 1995 to provide that the state courts *may* authorize an abortion under those circumstances. Because the amended statute afforded judges discretion in circumstances in which *Bellotti* had held that an order allowing an abortion was mandatory, the Fifth Circuit held that the statute contravened *Bellotti* on its face. *Id.* at 1108.

> [T]he plain language of [the statute] states that juvenile court judges within Louisiana have the discretion to deny an abortion to a minor even though the minor demonstrates that she is mature, well-informed, or that the abortion would be in her best interest. This flies in the face of *Bellotti II* and its progeny.

Indeed the sentence immediately preceding the language quoted by Petitioners in their parenthetical reiterates the

critical point upon which the holding was based: "Juvenile Court judges within Louisiana have a legislatively prescribed choice whether to order an abortion for a minor who is mature, well-informed, or for whom an abortion would be in her best interest." It was for this reason that the Fifth Circuit stated that "[i]t is th[e] discretion itself, and not the exercise of it, that we find inconsistent with *Bellotti II*." *Id.* at 1110. *Causeway* had absolutely nothing to do with "a standardless delegation of a veto power," as Petitioners suggest. It had everything to do with a state statute that flatly contradicted one of this Court's holdings that was directly on point.[12]

Petitioners' citations to this Court's cases also provide them with no basis for relief. Petitioners first suggest that the majority opinion in *Bryant II* conflicts with *City of Eastlake v. Forest City Enterprises, Inc.*, 426 U.S. 668 (1976). Again Petitioners are mistaken. In fact, in *Eastlake* the so-called non-delegation doctrine was found inapplicable because the case involved zoning decisions submitted by popular referendum to the people at large. In that circumstance, this Court concluded that the non-delegation doctrine was "inapplicable where, as here, rather than dealing with a delegation of power, we deal with a power reserved by the people to themselves." *Eastlake*, 426 U.S. at 675. Thus, *Eastlake* can simply provide Petitioners no support.

The language quoted from *Eastlake* in the Petition for Certiorari is from a section of the opinion in which the Court was explaining why its earlier cases did not require a different result than that reached in *Eastlake*. 426 U.S. at 677. One of the cases the Court was discussing, *Washington ex rel. Seattle Trust Co. v. Roberge*, 278 U.S. 116 (1928), is the other case from this Court with which Petitioners contend

12. Furthermore, even a cursory reading of the case indicates that a *Causeway*-like analysis takes place in the context of the undue burden determination. *Causeway* was itself a *Casey* challenge, and the *Casey* determination has already been fully and finally made with regard to Regulation 61-12.

the majority opinion in *Bryant II* conflicts. Thus, the State will turn its attention to that case.

Roberge involved a challenge to a municipal ordinance declaring that "[a] philanthropic home for children or for old people shall be permitted in First Residence District when the written consent shall have been obtained of the owners of two-thirds of the property within four hundred (400) feet of the proposed building." 278 U.S. at 118. The Court found this delegation to private property owners unconstitutional because the trustee that proposed to erect such a home had a constitutional right to "devote its land to any legitimate use" and the private property owners, in deciding whether to approve the proposed home, were "not bound by any official duty, but are free to withhold consent for selfish reasons or arbitrarily and may subject the trustee to their will or caprice." *Id.* at 121-22.

There are at least two reasons why *Roberge* does not control this case. The first is that, at least so far as admitting privileges at public hospitals are concerned, the hospitals are not entitled to "withhold consent for selfish reasons or arbitrarily" and are not free to "subject [physicians] to their will or caprice." It has been held as a matter of state law in South Carolina that "a public hospital cannot exclude a physician . . . from practice . . . by rules, regulations, or acts of the hospital's governing authorities, which rules, regulations, or acts have been described variously as unreasonable, arbitrary, capricious or discriminatory." *In re: Zaman*, 285 S.C. 345, 346, 329 S.E.2d 436, 437 (1985). Thus, physicians in South Carolina are entitled to due process in the public hospitals, and although Petitioners have attempted to make much of the fact that there is no way to ensure that private hospitals agree to form partnerships with abortion providers, there has been no allegation, no evidence, and no finding that the access to public hospitals is insufficient. Indeed, Petitioners have never had difficulty obtaining admitting privileges. A. 8-9.

Second, *Roberge* does not even apply to this case. As *Eastlake* made clear in its brief discussion of *Roberge*, the latter is about the delegation of *legislative* power. *Eastlake*, 426 U.S. at 677 (stating that *Roberge* involved "the delegation of *legislative* power . . . by the legislature to a narrow segment of the community" (emphasis added)). Unlike zoning decisions, there is nothing the least bit legislative about a hospital deciding whether it will grant admitting privileges to a physician. *Cf. Currin v. Wallace*, 306 U.S. 1, 15 (1939) (upholding provision of Tobacco Inspection Act declaring that no market for tobacco will be designated as such unless two-thirds of the growers vote in favor of it because the Act "does not involve any delegation of *legislative* authority" (emphasis added)); *Hornsby v. Allen*, 326 F.2d 605, 608 (5th Cir. 1964) ("[W]e do not conceive the denial of an application for a license to be an act of legislation.").[13]

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13. Petitioners actually cite to *Hornsby* as support for their argument that the Regulation is an unconstitutional delegation of authority. As with the other arguments Petitioners advance, numerous points could be made to refute Petitioners' attempt to rely on *Hornsby*. For present purposes, however, the State will simply make the following observations. *Hornsby* involved the denial of an application for a permit to sell liquor. Hornsby alleged, inter alia, that the denial was "arbitrary, unreasonable, unjust, capricious, discriminatory," and contrary to due process. *Hornsby v. Allen*, 326 F.2d 605, 607 (5th Cir. 1964). After holding that the permit process was in the nature of an adjudicatory act, the Fifth Circuit held that the due process requirements of notice and a hearing would apply. *Id.* at 608. The Court held that the allegations of Hornsby's complaint were sufficient to survive a motion to dismiss, because, if proven, they would establish that Hornsby was denied a fair hearing. As stated supra at page 20, the South Carolina appellate courts have held that physicians in South Carolina are entitled to due process with regard to decisions on admitting privileges. Furthermore, although the Fifth Circuit in *Hornsby* did state that one aspect of a fair hearing was "an opportunity to know . . . of the objective standards which had to be met to obtain a license," *id.* at 610, any suggestion that Petitioners do not know how to go about securing admitting privileges is belied by the fact that they have been able to obtain such privileges. *See id.* at 612 (holding that the question on remand was whether there were "ascertainable standards . . . by which an applicant can intelligently

(Cont'd)

When the above-quoted passage from the Petition for certiorari is read more closely, Petitioners' true argument becomes apparent. Petitioners object not so much to the requirement that physicians obtain admitting privileges than to the fact that, having made admitting privileges mandatory for abortion providers, the State did not absolutely require that hospitals grant admitting privileges to physicians that perform abortions. *See* Petition for Certiorari 26 (complaining that "[n]othing in the Regulation or South Carolina law prevents local hospitals from declining to apply for abortion certification or from denying a physician admitting privileges on the basis of the hospitals' opposition to abortion"). It is of course conceivable that at some future point the inability of physicians to make the necessary arrangements may amount to an undue burden on a woman's right to choose. Aside from the fact that the *Casey* challenge has already been heard and finally determined, the day has not yet come where the admitting-privileges requirement has had that effect. The Petitioners have been able to obtain the necessary privileges. A. 8-9.

And it bears noting that the same argument raised by Petitioners regarding the admitting-privileges requirement could be raised regarding a requirement that only physicians perform abortions. Namely, under Petitioners' theory, once a state imposes a physician-only requirement, the state must make sure that physicians do not decline to provide abortions based on their opposition to abortion. But this Court has never seen a problem with physicians-only requirements, *see Mazurek v. Armstrong*, 520 U.S. 968 (1997), and, similarly, there is no cause for alarm regarding the

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(Cont'd)

seek to qualify for a license"); *cf. Harris v. Lukhard*, 733 F.2d 1075, 1080 (4th Cir. 1984) (stating the concern of *Hornsby* and other similar cases was "to avoid both the reality and the appearance of arbitrary denial of benefits to potential beneficiaries") (internal quotation marks omitted)). Petitioners have never been denied admitting privileges, A. 8-9, and the fact that they have obtained them suggests quite obviously that the criteria for obtaining them is sufficiently clear.

admitting-privileges requirement. Employing basically this line of reasoning, the Eighth Circuit has recognized the similarity between the physicians-only requirement and the requirement that physicians performing abortions have surgical privileges in order to perform abortions:

> The requirement that physicians performing abortions obtain surgical privileges, which involves the independent action of a public or private hospital, poses no more significant threat to plaintiffs' due process rights than the requirement that those performing abortions be licensed physicians, which involves the independent action of a medical licensing board. Both requirements represent the state's legitimate effort to ensure that abortion is "as safe for the woman as normal childbirth at term . . . and is performed by medically competent personnel under conditions insuring maximum safety for the woman."

Woman's Health Center of West County, Inc. v. Webster, 871 F.2d 1377, 1382 (8th Cir. 1989). The Eighth Circuit thus upheld the surgical-privileges requirement and did so under its pre-*Casey* strict scrutiny standard. The point quite simply is that: (1) there is nothing facially problematic with requiring physicians providing abortions to obtain admitting privileges; and (2) if and when the admitting-privileges requirement gets to the point of imposing an undue burden on a woman's right to choose, this Court could visit the issue at that time. There is no reason to address the issue now, in the context of a case in which the challenged Regulation has survived a *Casey* challenge, and in which the Petitioners have had no difficulty obtaining the requisite admitting privileges. A. 8-9.

IV. GWC next argues that the *Bryant II* majority erred in applying *Salerno* to Petitioners' claim that § 103(c) of the Regulation is unconstitutionally vague. Petitioners assert that under the proper standard of vagueness review (which they never articulate), Section 103(c) must be stricken down as unconstitutional. Since Petitioners only make cursory arguments with regard to the vagueness issue, dedicating little more than a page in their thirty-page petition to the issue, the State will respond in kind.

Section 103 establishes a graduated penalty scheme for abortion facilities that are not in compliance with the Regulation. Subsection C provides that it shall be a Class III violation, the least serious category of violation, for a facility not to be in compliance with "the best practices as interpreted by the Department." A. 78. Petitioners focus solely on the "best practices" language in suggesting that this subsection of the Regulation is unconstitutionally vague. Petitioners overlook, however, several important aspects of Section 103 read as a whole. First, a "best practices" violation is a Class III violation, meaning that the first time a facility violates such a practice, nothing more than a warning is issued. This fact, of course, means that the facility will have notice that certain conditions violate the Regulation prior to ever incurring a monetary penalty. Furthermore, in deciding whether to impose a monetary penalty for a subsequent violation, Section 103(E) expressly directs inspectors to consider the "*specific conditions* and *their impact on health, safety, and well-being*; efforts by the facility to correct; overall conditions; history of compliance; any other pertinent conditions that may be applicable to *current statutes and regulations*." A. 79. Thus, the regulation makes clear that the "best practices" violation: (1) must have some relation to "health, safety, and well-being;" (2) must either relate to the requirements of Regulation 61-12 or other "current statutes and regulations;" (3) and that inspectors must identify the "specific conditions" thought to run afoul of requirements. There is, therefore, adequate limitation on inspectors' discretion. Furthermore, if a facility is of the

opinion that an inspector has exceeded his limited discretion under the Regulation, the facility can request an administrative hearing. A. 79. These facts support the conclusion of the *Bryant II* majority that § 103(c) of the Regulation is not unconstitutionally vague, and this Court should deny the request for a writ of certiorari on that issue.

CONCLUSION

For all of the foregoing reasons, the State respectfully requests that the Court deny the Petition for a Writ of Certiorari.

Respectfully submitted,

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MOTION FILED
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No. 02-1235

IN THE
SUPREME COURT OF THE UNITED STATES

GREENVILLE WOMEN'S CLINIC, et al.,
Petitioners,

v.

COMMISSIONER, SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL, et al.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN PUBLIC HEALTH ASSOCIATION, AND SOUTH CAROLINA MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

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24 pp

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Supreme Court Rule 37.2(b), *Amici Curiae* move for leave to file the attached brief in support of the Petition for Writ of Certiorari filed by Greenville Women's Clinic, et al., seeking review of *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control*, 306 F.3d 141 (4th Cir. 2002).

In support of this Motion, *Amici Curiae* state as follows:

1. *Amici Curiae* are three medical and public health organizations whose members will be directly affected by the challenged regulation.

2. *Amicus Curiae* American College of Obstetricians and Gynecologists is a private, voluntary, not-for-profit organization representing over 90% of all obstetricians and gynecologists currently practicing in the United States, including almost 600 members in South Carolina.

3. *Amicus Curiae* American Public Health Association is a national organization devoted to the promotion and protection of personal and environmental health and representing over 50,000 public health professionals.

4. *Amicus Curiae* South Carolina Medical Association is the primary professional association for individuals licensed to practice medicine in South Carolina and has over 5500 members representing all medical specialties that provide medical services to the citizens of the state.

5. *Amici Curiae* each have expertise in the proper maintenance of individually identifiable medical records.

6. *Amici Curiae* seek permission to submit this Brief in order to assist the Court in its consideration of Petitioners' first question presented for review—whether the challenged regulation violates the constitutional right to informational privacy. Specifically, *Amici Curiae* seek to highlight the importance of confidentiality to the medical profession

generally as well as to the provision of reproductive health care in particular.

7. *Amici Curiae* have sought consent of the parties to the filing of this Brief. Petitioners have consented to the filing of the Brief, and Respondents have denied consent.

For the foregoing reasons, *Amici Curiae* respectfully move for leave to file the attached Brief *Amici Curiae* in Support of Petitioners.

Respectfully submitted,

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STATEMENTS OF INTEREST[1]

Amicus Curiae American College of Obstetricians and Gynecologists (ACOG), founded in 1951, is a private, voluntary, not-for-profit organization and the leading group of professionals providing health care to women. ACOG's more than 45,000 members represent over 90% of all obstetricians and gynecologists currently practicing in the United States, including almost 600 members in South Carolina. ACOG is dedicated to educating health care professionals, law and policy makers, and the general public about women's health care. ACOG supports women's confidential access to reproductive health services and supports strong legal protection for records that contain private medical information. ACOG submits this brief out of concern that the challenged South Carolina regulation jeopardizes the health of South Carolina women by compromising their right to confidential health care.

Amicus Curiae American Public Health Association (APHA) is a national organization devoted to the promotion and protection of personal and environmental health. Founded in 1872, APHA is the largest public health organization in the world, representing over 50,000 public health professionals. It represents all disciplines and specialties in public health, including maternal and child health. APHA strives to improve public health for everyone by proposing solutions based on research, helping to set public health practice standards, and working closely with national and international health agencies. APHA believes patient confidentiality is essential to ensuring that patients receive timely and appropriate medical treatment, including reproductive health services.

Amicus Curiae South Carolina Medical Association (SCMA) is the primary professional association for

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[1] No entity or counsel apart from those whose names appear on this Brief have contributed monetarily or substantively to its production. Sup. Ct. R. 37.6.

individuals licensed to practice medicine in South Carolina. The SCMA has over 5500 members representing all medical specialties that provide medical services to the citizens of the state. The SCMA's primary mission is to foster high ethical and clinical standards for the practice of medicine in South Carolina. To this end, SCMA opposes policies and practices, like the regulation at issue here, that undermine patient confidentiality and weaken the trust between health care providers and patients that promotes positive treatment outcomes.

SUMMARY OF ARGUMENT

This Court should review the decision of the U.S. Court of Appeals for the Fourth Circuit because of the harmful impact that decision will have on the practice of medicine generally and the provision of reproductive health services specifically. South Carolina Regulation 61-12 § 102(F)(2) (the disclosure provision) plainly violates basic principles of medical confidentiality recognized as essential to the practice of medicine by leading medical and public health organizations in the United States.

Compromising patient confidentiality will impair the atmosphere of honesty and openness that physicians must create if they are to convince their patients to trust them with the sensitive personal information needed to provide appropriate treatment. Nowhere is this trust more critical than in the provision of gynecological and reproductive health services. Indeed, as this Court has repeatedly recognized, the denial of confidentiality in the provision of reproductive health services amounts, for many women, to the denial of the right to choose altogether.

The impact of permitting the disclosure provision to stand extends well beyond the abortion context. For women affected by the provision, not only will reproductive health information be exposed but so will any other information

recorded in their files. Furthermore, because there is no limiting principle within the Court of Appeals' reasoning, the decision below is a harbinger for the erosion of doctor-patient confidentiality in all areas of medicine. As a result, patients in South Carolina and elsewhere will face the prospect of never knowing whose eyes may be inspecting their medical records.

For these reasons, and for those set forth in the Petition for Certiorari, this Court should grant the Petition.

ARGUMENT

I. The Disclosure Provision Conflicts With the Professional Ethical Guidelines and Policy Statements of Major Medical Organizations.

As detailed in the Petition for Certiorari, the Court of Appeals erred in concluding that the disclosure provision and South Carolina law[2] protect patients from the disclosure of personally identifiable medical information. *See* Pet. for Cert. at 9-11. Moreover, whether South Carolina law is read to allow only the state agency access to records, as the majority opinion of the Court of Appeals read it, or to allow broad public access to records, as Petitioners and the dissent read it, confidentiality of medical records is shattered.

Accordingly, the disclosure provision conflicts with major medical groups' policies regarding doctor-patient confidentiality. The provision would render South Carolina's obstetricians and gynecologists incapable of adhering to the Code of Conduct of the American College of

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[2] The disclosure provision gives the Department of Health and Environmental Control (DHEC) access to all clinic records and the authority to photocopy those documents. S.C. Code Ann. Regs. 61-12 § 101(F)(2). Other sections of South Carolina law give the public access to documents in DHEC's possession. *See* S.C. Code Ann. § 44-7-310; S.C. Code Ann. § 44-7-315; *see generally* Pet. for Cert. at 4, 9-11.

Obstetricians and Gynecologists (ACOG), which mandates that the physician "safeguard patient information and confidences . . . ." Am. Coll. of Obstetricians & Gynecologists, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists: Code of Conduct* (2001), *available at* http://www.acog.org/from_home/acogcode.pdf.

Similarly, physicians and medical professionals in other specialties who are covered by the disclosure provision[3] will also face difficulties complying with their professional obligations. For instance, the American Academy of Family Physicians stresses the importance of confidentiality: "A confidential relationship between physician and patient is essential for the free flow of information necessary for sound medical care." Am. Acad. of Family Physicians, *AAFP Policies on Health Issues: Confidentiality, Patient/Physician* (2000), *available at* http://www.aafp.org/x6686.xml; *see also* Am. Acad. of Pediatrics, *Policy Statement: Confidentiality in Adolescent Health Care (RE9151)* (April 1998), *available at* http://www.aap.org/policy/104.html. The American Society of Internal Medicine's Ethics Manual states that "[c]onfidentiality is a fundamental tenet of medical care. It is a matter of respecting the privacy of patients, encouraging them to seek medical care and discuss their problems candidly, and preventing discrimination on the basis of their medical conditions. The physician must not release information without the patient's consent . . . ." Am. Coll. of Physicians–Am. Soc'y of Internal Med., *Ethics Manual* (4th ed. 1998), *available at* http://www.acponline.org/journals/annals/01apr98/ethicman.htm. The American Society of General Surgeons agrees that "[p]atients should not be denied

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[3] Because the disclosure provision applies to all medical records maintained by "[a]ny facility, other than a hospital, . . . in which any second trimester or five or more first trimester abortions are performed in a month," *see* S.C. Code Ann. Regs. 61-12 § 101(B), the disclosure provision affects not only physicians providing abortion services, but also physicians providing any of a wide array of general medical services in any covered facility.

the right to communicate with health care providers in confidence, and have the confidentiality of their communications (and their medical records) protected against unauthorized use." Am. Soc'y of Gen. Surgeons, *Patients' Rights: ASGS Statement of Principles* (1999), *available at* http://www.theasgs.org/about.asgs/ps/ps5.html. Also, the Code of Ethics for the American Nurses Association requires the maintenance of confidentiality of all patient information: "The patient's well-being could be jeopardized and the fundamental trust between patient and nurse destroyed by unnecessary access to data or by the inappropriate disclosure of identifiable patient information." Am. Nurses Ass'n, *Code of Ethics for Nurses with Interpretative Statements* § 3.2 (2001), *available at* http://nursingworld.org/ethics/code/ethicscode150.htm.

General ethical obligations of doctors are also contravened by the disclosure provision. The Fourth Principle of Medical Ethics of the American Medical Association (AMA) requires that "[a] physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard confidences and privacy . . . ." Am. Med. Ass'n, *Principles of Medical Ethics* (June 2001), *available at* http://www.ama-assn.org/ama/pub/category/2512.html. The World Medical Association requires the physician to "safeguard patient confidences" and "preserve absolute confidentiality on all he knows about his patient even after the patient has died." World Med. Ass'n, *World Medical Association International Code of Medical Ethics* (1983), *available at* http://www.wma.net/e/policy/17-a_e.html. The American Public Health Association stresses that "[t]he constitutional rights and privacy of individuals must be protected with respect to the accumulation and dissemination of personal information." Am. Public Health Ass'n, *Public Policy Statement 6608* (1966), *available at* http://www.apha.org/legislative/policy/PDF/66Policy.pdf.

These overarching obligations applicable to all doctors stem from the Hippocratic Oath: "What I may see or hear in the course of the treatment or even outside of the treatment in

regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about." Hippocratic Oath (quoted in Albert R. Jonsen et al., *Clinical Ethics* 166 (4th ed. 1998)).

Guidelines specifically governing the maintenance of medical records squarely conflict with the disclosure provision. The AMA Council on Ethical and Judicial Affairs, responsible for explicating the organization's Principles of Medical Ethics, has stated unequivocally that the medical record must be given the highest protection of confidentiality: The "record is a confidential document involving the patient-physician relationship and should not be communicated to a third party without the patient's prior written consent . . . ." Council on Ethics & Judicial Affairs, Am. Med. Ass'n, *E-7.02: Records of Physicians: Information and Patients* (1994), *available at* http://www.ama-assn.org/ama/pub/category/8378.html. "[T]here exists a basic right of patients to privacy of their medical information and records," and "this right should be explicitly acknowledged." Am. Med. Ass'n, *PolicyFinder, H-315.983(1): Patient Privacy and Confidentiality* (2002), *available at* http://www.ama-assn.org/apps/pf_online/pf_online?f_n=browse&doc=policyfiles/HOD/H-315.983.HTM. By allowing government and public third parties to access patients' medical records, the disclosure provision requires what the AMA's Council on Ethical and Judicial Affairs specifically forbids.

In the limited circumstances when personal medical information must be disclosed,[4] the AMA's ethical

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[4] ACOG, the AMA, and various other organizations permit disclosure of information as required by law. However, these exceptions are narrowly circumscribed based on "overriding social considerations." Council on Ethics & Judicial Affairs, Am. Med. Ass'n, *E-5.05: Confidentiality* (1994), *available at* http://www.ama-assn.org/ama/pub/category/8353.html. Such "overriding social considerations" are generally limited to situations in which non-disclosure could seriously harm other individuals, such as when a patient threatens to inflict serious bodily harm to another or to herself or, as required by applicable reporting statutes, when a patient presents with serious communicable diseases, gun-shot and knife

guidelines require that any information disseminated "should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure," *id.* ¶ (1)(d), and should be "de-identified" whenever possible. *Id.* ¶ (4). Such disclosures "must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end." *Id.* ¶ (8).

In direct contrast to these widely-accepted principles of medical confidentiality, the disclosure provision requires physicians to disclose all medical records maintained by facilities that fall under the regulation's definition of abortion clinic without obtaining patient consent or redacting identifying or sensitive information. Furthermore, the records must be disclosed in their entirety even when a more narrowly tailored disclosure would fulfill the purpose of the regulation. Ultimately, physicians are in an ethical and legal quandary: if they choose to obey the law, they will have to disobey the fundamental ethical principles of their profession, and if they choose to follow their field's guiding doctrines, they will be forced to disobey the law. The disclosure provision forces South Carolina physicians to violate the fundamental principles of their profession, as they cannot guarantee their patients even the most basic elements of medical confidentiality.

This Court has recognized the importance of medical confidentiality in protecting doctor-patient relationships. *See Ferguson v. City of Charleston*, 532 U.S. 67, 78 (2001) (stating that "[t]he reasonable expectation of privacy enjoyed by the typical patient undergoing diagnostic tests in a hospital is that the results of those tests will not be shared with nonmedical personnel without her consent"). Because

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wounds, or indicia of child abuse. *Id.*; *see also* Am. Coll. of Obstetricians & Gynecologists, *Guidelines for Women's Health Care* 66 (2d ed. 2002). None of these "overriding social considerations" has been or could be offered as a justification for the disclosure provision.

the disclosure provision vitiates such confidentiality, this Court is urged to grant review.

II. Protecting Medical Confidentiality Is Essential to Respecting Patient Autonomy and Providing Effective Medical Care.

Confidentiality is essential to effective medical care. Without its promise, the practice of medicine becomes dangerous as patients will either avoid care altogether or be less than completely honest with health professionals, not giving doctors the complete information they need in order to make medically sound decisions.

Without assurances of medical confidentiality, patients at South Carolina abortion clinics will face all the harms that the principles of medical confidentiality exist to prevent. Respect for patient privacy protects "patient autonomy and is a prerequisite to building the trust that is at the core of the patient-physician relationship." Council on Ethics & Judicial Affairs, Am. Med. Ass'n, *E-5.059: Privacy in the Context of Health Care* (2002), *available at* http://www.ama-assn.org/ama/pub/category/8623.html. As the American Association of Family Practitioners has stated, "[o]nly in a setting of trust can a patient share the private feelings and personal history that enable the physician to comprehend fully, to diagnose logically and to treat properly." Am. Acad. of Family Physicians, *AAFP Policies on Health Issues: Confidentiality, Patient/Physician* (2000), *available at* http://www.aafp.org/x6686.xml. Without that trust, patients will not be completely candid with their doctors, which could result in patients withholding "information vital to their care or [being] reluctant to seek care altogether." Patricia I. Carter, *Health Information Privacy: Can Congress Protect Confidential Medical Information in the "Information Age"?*, 25 William Mitchell L. Rev. 223, 232 (1999).

Furthermore, "unauthorized disclosure of information could result in embarrassment, stigma, and discrimination." Lawrence O. Gostin, *Legislative Survey of State Confidentiality Laws* at § III (1997), *at* http://www.epic.org/

privacy/medical/cdc_survey.html. Medical records may contain a wide range of highly sensitive information, such as information indicating that the patient suffers from cancer, heart disease, substance abuse and addiction, or a psychiatric problem. Gynecological records in particular may contain detailed information about the patient's sexual practices, disclosures about the patient's sexual orientation, and details about contraceptive usage, menstrual cycles, sexual dysfunction, fertility problems, or sexually transmissible infections. Medical records of sexual assault survivors may contain photographs of the victim's injuries and detailed accounts of her psychological and physical condition. Should the disclosure provision stand, conscientious doctors will hesitate to record such sensitive information in their patient's medical chart because of the likelihood that it will become public.

Under the disclosure provision, South Carolina doctors cannot guarantee that sensitive and identifiable information about their patients will remain confidential. The trust they need to establish with their patients will be tainted, if not destroyed. Giving the state and inquisitive South Carolinians unfettered access to individuals' medical records, as the disclosure provision does, will cause significant harm. Because of the grave consequences that approval of the disclosure provision could have on the practice of medicine, *Amici* urge this Court to grant certiorari.

III. This Court Should Grant Certiorari Because Protecting the Confidentiality of Medical Treatment Information Is of Paramount Importance in the Provision of Reproductive Health Services.

As critically important as the privacy of medical treatment information is generally, it is even more vital in the context of reproductive health services. This Court's abortion jurisprudence has zealously protected abortion decisions from disclosure to others as well as from direct interference by the state. *See, e.g., Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 900-01 (1992); *Bellotti v. Baird,* 443 U.S. 622 (1979). This

vigilance is appropriate and necessary: reproductive health care decisions are by their nature uniquely personal, often revolving around intimate family considerations and engaging the patient's most profound convictions and beliefs. Indeed, this Court has recognized that these choices about family and personal destiny lie at the heart of one's self-definition. *Casey*, 505 U.S. at 856.

Strict confidentiality of abortion information is also necessary because women's ability to obtain an abortion depends upon it, much in the same way that a secret ballot is integral to the protection of the right to vote. For some vulnerable patients, disclosure or the threat of disclosure will prevent them from obtaining an abortion altogether; for others, the price of exercising their right will be damage to career or educational goals, harassment and abuse, or outright physical assault and bodily injury. If the Court of Appeals' decision is permitted to stand, doctors will face untenable conflicts between their duty to protect their patients' welfare and the duties imposed on them by law.

A. Women Who Choose Abortion Will Face the Threat of Harassment, Violence, and Discrimination If Their Decision Is Made Public.

Women and their doctors face the threat of harassment and violence if their abortion decision is made public. As the Senate Committee report accompanying the Freedom of Access to Clinic Entrances Act noted, "[a] nationwide campaign of anti-abortion blockades, invasions, vandalism and outright violence is barring access to facilities that provide abortion services and endangering the lives and well-being of the health care providers who work there and the patients who seek their services." Senate Comm. on Labor & Human Resources, 103d Cong., *Report on Freedom of Access to Clinic Entrances Act (S. 636)* 3 (1993) (subsequently enacted at 18 U.S.C. § 248) (noting that from 1977 to April 1993, more than 1,000 acts of violence against abortion providers were reported in the United States, including at least 36 bombings, 81 arsons, 131 death threats, 84 assaults, two kidnappings, 327 clinic invasions, and over

6,000 clinic blockades). Nor has this violence ended: since 1993, there have been thousands of violent offenses against abortion providers, including bombings, arsons, chemical attacks, and anthrax threats. *See* Nat'l Abortion Federation, *Incidents of Violence and Disruption Against Abortion Providers* (Dec. 31, 2002), *at* http://www.prochoice.org/; *see also* Carol Mason, *Killing for Life: The Apocalyptic Narrative of Pro-Life Politics* (2002).

Women whose identities are known to anti-abortion protesters are highly likely to face harassment and the loss of all personal privacy about their decision. *See* App. 34 (protesters using 15-year old's medical record); Rachel L. Braunstein, *A Remedy for Abortion Seekers Under the Invasion of Privacy Tort*, 68 Brook. L. Rev. 309, 309-10 (2002) (describing website that posts the pictures of individual women seeking abortions). As this Court has seen in the record of past cases, women who are harassed and threatened prior to their abortion procedures can suffer negative health consequences as a result. *Madsen v. Women's Health Center*, 512 U.S. 753, 758 (1994) (noting toll protests and harassment take on patients seeking abortion).

Women who seek abortion services are also subjected to discrimination based on their decision. Indeed, the Pregnancy Discrimination Act, 42 U.S.C. § 2000e(k), was enacted in order to address widespread discrimination against women on the basis of the condition of pregnancy, including discrimination based on an individual's abortion decisions. *See EEOC Questions & Answers*, 29 C.F.R. 1604 app. at 204; *Turic v. Holland Hospitality, Inc.*, 85 F.3d 1211, 1214 (6th Cir. 1996); *Doe v. First Nat'l Bank of Chicago*, 668 F. Supp. 1110, 1113 (N.D. Ill. 1987), *aff'd without deciding issue* 865 F.2d 864 (7th Cir. 1989). Should the decision below be permitted to stand, South Carolina women seeking abortion services can contemplate that, if their decision is revealed to their employer, landlord, neighbors, or school principal, they may face the same discriminatory conduct inflicted on the plaintiffs in the cases cited above.

B. Domestic Violence and Sexual Assault Survivors Seeking Reproductive Health Services Will Face Serious Danger If Their Medical Records Are Made Public.

For some women seeking reproductive health services, disclosure can have catastrophic consequences. Domestic violence is one of the nation's most pervasive public health problems. As detailed by this Court, domestic violence affects millions of women every year. *See Casey*, 505 U.S. at 887-94. The National Institute of Justice and the Centers for Disease Control and Prevention estimate that 25% of women have been physically assaulted and/or raped by a current or former spouse, cohabiting partner, or date at some time in their lives. Patricia Tjaden & Nancy Thoennes, National Institute of Justice/Centers for Disease Control and Prevention, *Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey* 2, 12 (1998). Domestic violence is often lethal: 30% of women killed in the United States were murdered by their husbands or partners. U.S. Dep't of Justice, Bureau of Justice Statistics, *Intimate Partner Violence* 1 (2000) (reporting that the percentage of female murder victims killed by intimate partners has remained at about 30% since 1976). So pervasive is the problem that ACOG recommends universal screening of all female patients for domestic abuse: "Because of the prevalence of violence, being female is a significant enough risk factor to warrant screening every patient at periodic intervals, such as annual examinations and new patient visits." ACOG Educational Bulletin No. 257 at 3, *in* 94(6) *Obstetrics & Gynecology* (Dec. 1999).

When a patient discloses that she is a victim of domestic violence, confidentiality is absolutely essential to protect her from retaliatory assaults. ACOG's educational materials counsel physicians to alter their billing and patient contact procedures to ensure that the battered patient's confidentiality is not breached: "Because perpetrators often retaliate when they suspect disclosure of abuse, every effort

should be made to maintain confidentiality, especially regarding telephone calls or when materials, such as bills, are sent to the patient." *Id.* at 5.

When medical treatment includes reproductive health care, ensuring the patient's medical privacy is particularly important. Acknowledging the danger that domestic violence survivors face from their abusers, this Court has recognized the importance of maintaining the confidentiality of a decision to obtain an abortion for women in a relationship infused with violence:

> Should these women become pregnant, they may have very good reasons for not wishing to inform their husbands of their decision to obtain an abortion. Many may have justifiable fears of physical abuse, [may] fear notifying their husbands will provoke further instances of child abuse, [or] may fear devastating forms of psychological abuse[,] including verbal harassment, threats of future violence, the destruction of possessions, physical confinement to the home, the withdrawal of financial support, or the disclosure of the abortion to family and friends.

Casey, 505 U.S. at 893. Confidentiality, in these situations, is "critical to ensuring a woman's safety." *See* Am. Coll. of Obstetricians & Gynecologists, *Guidelines for Women's Health Care* 15 (2d ed. 2002). The disclosure provision denies this necessary confidentiality and thus brings about the harms this Court has recognized as important to avoid.

The disclosure provision also presents a troubling dilemma for doctors who are faced with deciding how they should document a history of domestic abuse in patients' medical records. Physicians play a critical role in the identification of domestic violence and intervention on behalf of the victim, and accurate documentation of domestic violence can assist a victim in putting an end to the abuse.

Documentation will assist her, for example, in getting a protection order and other medical, legal, and social services that may save her life and the lives of her children; it will also permit her to avail herself of the Family Violence Option, a welfare option that protects domestic violence survivors from the dangers of complying strictly with welfare program requirements and time limits. *See* 42 U.S.C. § 602(a)(7); Temporary Assistance for Needy Families Program, 62 Fed. Reg. 62124, 62128-29 (Nov. 20, 1997). In addition, medical record documentation "can help validate the recurrent nature of the problem and provide important supportive evidence in the courtroom." ACOG Educational Bulletin No. 257, *supra*, at 5.

However, faced with the disclosure provision, practitioners may deliberately keep important information about domestic violence out of a patient's medical record if they determine that the patient will be exposed to greater danger from disclosure of the medical record. Failing to keep accurate and complete records about domestic violence not only will harm the patient in her pursuit of services to which she is entitled, but is also contrary to the best practices of the medical profession and conflicts with the advice of the nation's leading public health authorities and domestic violence experts. *See, e.g.*, ACOG Educational Bulletin No. 257, *supra*, at 5; Am. Med. Ass'n, PolicyFinder, *H-515.965(3)(i): Family and Intimate Partner Violence* (2000), *available at* http://www.ama-assn.org/apps/pf_online/pf_online?f_n=browse&doc=policyfiles/HOD/H-515.965.HTM.

Similarly, doctors face a conflict between their professional obligations and the disclosure provision when treating indigent rape and incest survivors. Rape is largely unreported. *See* Callie Rennison, *Bureau of Justice Statistics: National Crime Victimization Survey: Criminal Victimization 2001* at 10 (2002) (indicating rape is most underreported violent crime, with just under 39% being reported to police). The two most frequently cited reasons for this underreporting are that women believe that the incident is a private matter or they fear reprisals from the

rapist. *See* Callie Marie Rennison, *Bureau of Justice Statistics: Selected Findings: Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2000* at 3 (2002).

Yet both federal and state law entitle indigent women receiving their health care through the Medical Assistance Program to obtain a funded abortion if their pregnancy was caused by rape. *See* Hyde Amendment, Pub. L. No. 107-116, 115 Stat. 2177 (2002); S.C. Code Ann. § 1-1-1035. Recognizing that many women who have been sexually assaulted are unable to make a police report for physical or psychological reasons, both federal and state law permit the patient to qualify for a funded abortion without making a police report if the physician documents that the patient is unable to report due to physical or psychological reasons. *See* S.C. Dep't Health & Human Servs., Medicaid Bulletin: Abortion Statement (July 21, 1999); 1999 S.C. Acts 100 § 72.87 (1999); *see also Elizabeth Blackwell Health Center for Women v. Knoll*, 61 F.3d 170 (3d Cir. 1995). However, because the disclosure provision subjects the medical records of rape victims seeking reproductive health services to possible public scrutiny, doctors will face a dilemma: they can either document the rape in the unprotected medical record that may well become public, or they can advise their patient that the risk of public disclosure is too great and the patient should forego public funding. The latter option would likely delay the procedure, thus increasing the health risks associated with it, while the patient struggles to raise the fee for the abortion through other means.

CONCLUSION

The disclosure provision places physicians in an untenable bind: if they competently and diligently practice their profession, they may expose their patients and themselves to serious risks; and if they attempt to minimize those risks, they may be compromising the care they give their patients. For this and all the foregoing reasons, as well

as those contained in the Petition for Certiorari, *Amici Curiae* respectfully request that this Court grant the Petition.

Respectfully submitted,

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IN THE

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GREENVILLE WOMEN'S CLINIC, ET AL.,
Petitioners,

v.

COMMISSIONER, SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL, ET AL.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals For the Fourth District

MOTION OF THE NATIONAL ABORTION FEDERATION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONERS AND BRIEF *AMICUS CURIAE*

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MOTION OF THE NATIONAL ABORTION FEDERATION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Rule 37.2 of the rules of this Court, the National Abortion Federation ("NAF") respectfully moves the Court for leave to file the attached brief *amicus curiae* in support of the petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit in *Greenville Women's Clinic v. Commissioner*, 317 F.3d 357, 367 (4th Cir. 2002). Petitioners have consented to the filing of the attached brief. Respondent has declined to consent. Copies of Petitioners' letter giving consent are on file with the Clerk of the Court.

In this case, the Fourth Circuit upheld a regulation promulgated by the South Carolina Department of Health and Environmental Control ("DHEC") that permits the Department to review, copy, and retain abortion patients' medical

records and that will result in the public disclosure of information personally identifying abortion patients. This public disclosure is of fundamental interest to NAF, a non-profit professional organization of abortion providers. Both the DHEC and the Fourth Circuit improperly relied on standards published by NAF to demonstrate the DHEC's need for copying and retaining abortion patients' medical records. In fact, NAF's standards do not support disclosure of medical records without protection of patients' personally identifying information. Breaches of patient confidentiality will also seriously compromise women's access to safe, legal abortions in South Carolina, and will put both abortion providers and patients at increased risk of harassment and violence in that State.

NAF is in a unique position to aid the Court in its consideration of the issues presented. NAF's members provide over half the abortions in the United States. NAF publishes comprehensive standards for abortion providers, and NAF compiles statistics on the harassment and violence directed toward abortion patients and providers. Accordingly, NAF respectfully requests that the Court grant this motion for leave to file a brief *amicus curiae*.

Respectfully submitted,

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On Petition for a Writ of Certiorari to the United States Court of Appeals For the Fourth District

BRIEF OF THE NATIONAL ABORTION FEDERATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

INTEREST OF *AMICUS CURIAE*[1]

The National Abortion Federation ("NAF") submits this brief *amicus curiae* in support of Petitioners, Greenville Women's Clinic and William Lynn, M.D., on behalf of themselves and their patients seeking abortions, urging writ of certiorari to review the judgment of the Fourth Circuit Court of Appeals, which upheld a South Carolina regulation

[1] Pursuant to Rule 37.6, *amicus* states that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *amicus*, or its members or counsel, made any monetary contribution to the preparation or submission of this brief.

governing the licensing and operation of abortion clinics, S.C. Code Ann. Regs. 61-12.

NAF is a non-profit professional organization dedicated to preserving the right of all women to choose a safe, accessible, and legal abortion. Founded in 1977, NAF's members include almost 400 non-profit and private clinics, women's health centers, Planned Parenthood facilities and private physicians' offices in 47 states and 8 provinces in Canada. NAF's members provide over half of the abortions performed in the United States each year. NAF publishes comprehensive standards for abortion providers and is the only organization that provides accredited, abortion-specific, continuing medical education in all aspects of abortion care.[2] NAF is also one of the primary organizations that collects and disseminates information on the harassment of and violence against abortion providers and patients.

The issues at stake in this case are of immediate concern to NAF and its members. As an organization devoted to ensuring quality abortion care in the United States, NAF is deeply committed to protecting the confidentiality of women who seek to obtain abortions. The doctor-patient relationship is of paramount importance to the provision of safe abortion care, and it is imperative that patients be able to trust that their private information is secure. Breaches of patient confidentiality can be particularly dangerous in the context of abortion, given the current level of harassment and violence against both abortion providers and patients. Moreover, the Fourth Circuit relied on a misreading of NAF's standards in concluding that the Regulation is constitutional. NAF thus seeks to clarify the meaning of its standards.

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[2] NAF has been termed a "mini-AMA" for abortion providers by the New York Times. Jack Hitt, *Who Will Do Abortions Here?*, N.Y. Times Magazine, Jan. 18, 1998, at 20.

STATEMENT

In this case, the United States Court of Appeals for the Fourth Circuit upheld a provision of South Carolina Regulation 61-12 (hereinafter the "Regulation") that permits the State to review, copy, and retain abortion patients' medical records without protecting any personally identifying information in those records from public disclosure. The provision requires that abortion clinics give inspectors from the South Carolina Department of Health and Environmental Control ("DHEC") "access to all properties and areas, objects, records and reports," and the provision further states that the inspectors "shall have the authority to make photocopies of those documents required in the course of inspections or investigations." S.C. Code Ann. Regs. 61-12, § 102(F)(2).

The Regulation was promulgated by the DHEC in 1995, and it imposes comprehensive licensing and operational requirements on "facility[ies] in which any second trimester or five or more first trimester abortions per month are performed." S.C. Code Ann. Regs. 61-12, § 101(B). In 1996, the Greenville Women's Clinic, the Charleston Women's Clinic, and William Lynn, M.D., on behalf of themselves and their patients, challenged the constitutionality of the Regulation.[3] Plaintiffs-Petitioners argued that the Regulation violates their constitutional rights and their patients' constitutional rights under the Due Process Clause, the Equal Protection Clause, and the Establishment Clause.

The district court granted Plaintiffs-Petitioners declaratory and injunctive relief, holding that the Regulation unduly burdens women's right to choose an abortion in violation of the Due Process Clause and that the Regulation distinguishes unreasonably between clinics in violation of the Equal Pro-

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[3] As Petitioners' explain in their brief, the Charleston Women's clinic is not a petitioner at this stage in the proceedings. *See* Pet. Br. 11 n.1.

tection Clause. *Greenville Women's Clinic v. Bryant*, 66 F. Supp. 2d 691 (D.S.C. 1999). The Fourth Circuit reversed, and the Supreme Court denied Plaintiffs-Petitioners' petition for certiorari. *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000), *cert. denied*, 531 U.S. 1191 (2001).

On remand, the district court addressed Plaintiffs-Petitioners remaining claims, dismissing all but Plaintiffs-Petitioners' claim that the Regulation violated their informational privacy rights. *Greenville Women's Clinic v. Bryant*, No. 6:96-1898, slip op. (D.S.C. Aug. 31, 2001).[4] Over a dissent by Judge King, the Fourth Circuit again reversed the judgment of the District Court. *Greenville Women's Clinic*, 317 F.3d at 371. Plaintiffs-Petitioners petitioned for rehearing *en banc*, and the Fourth Circuit initially granted the petition; however, the Circuit vacated the grant one week later.

ARGUMENT

I. THE FOURTH CIRCUIT'S DECISION PERMITS THE PUBLIC DISCLOSURE OF ABORTION PATIENTS' PERSONALLY IDENTIFYING INFORMATION.

Under the Regulation, the DHEC is not required to remove patients' personally identifying information from any records and reports it reviews, copies, and retains. S.C. Code Ann. Regs. 61-12. This Court has held that patients have a protected interest "in avoiding disclosure of personal matters." *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977). The right to informational privacy, as this interest has been

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[4] The district court found that, because South Carolina identified "no compelling interest in the disclosure of identifying information'—i.e., information that reveals to the State the names of patients procuring abortions—§ 102(F)(2) violates the patient's constitutional right to privacy 'insofar as it requires access to identifying information.'" *Greenville Women's Clinic v. Commisioner*, 317 F.3d 357, 367 (4th Cir. 2002) (quoting *Greenville Women's Clinic v. Bryant*, No. 6:96-1898, slip op. (D.S.C. Aug. 31, 2001)).

termed, has been upheld and expanded by the majority of federal Courts of Appeal. *See* Pet. Br. 12 (listing cases).[5]

Instead of weighing abortion patients' privacy interests against the State's interest in disclosure, however, the Fourth Circuit wrongly concluded that, because other state statutes purport to prevent the *public* disclosure of patients' private medical information, the Regulation does not violate women's constitutional privacy rights. *See Greenville Women's Clinic*, 317 F.3d at 370-71. *First*, the Fourth Circuit's methodology in analyzing Plaintiffs-Petitioners' constitutional privacy claim puts it at odds with the majority of the circuits. As Petitioners discuss at greater length in their brief, the Fourth Circuit's failure to balance individual patients' interests against the State's interest has moved the circuit from the majority of circuits to the minority of circuits. *See* Pet. Br. 11-20.[6]

Second, it is clear that other state statutes will not prevent the public disclosure of abortion patient's personally identifying information. As Petitioners also discuss at greater length in their brief, it is uncontested that the DHEC is authorized to disclose personally identifying information

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[5] For instance, the Ninth Circuit has explicitly extended *Whalen* to the disclosure of personally identifying information in the abortion context. *See, e.g., Planned Parenthood of S. Arizona v. Lawall*, 307 F.3d 783, 789-90 (9th Cir. 2002). In these other circuits, an individual's right to informational privacy is weighed against a state's interest in disclosure of the individual's personal information. *See, e.g., id.* at 790 ("in evaluating an informational privacy claim, the Court engages in the delicate task of weighing competing interests") (internal quotation marks and citation omitted).

[6] In an earlier case, the Fourth Circuit had applied a balancing test to an informational privacy claim. *See Walls v. City of Petersberg*, 895 F.2d 188 (4th Cir. 1990); *see also* Pet. Br. 15 ("The decision below significantly adds to [the circuit split] by moving the Fourth Circuit from the position held by the majority of circuits to the minority position requiring nothing more that a rational basis to require significant privacy intrusions.").

about abortion patients in proceedings "involving the licensure or certification of need of the [abortion] facility or licensing proceedings against an employee of the facility." S.C. Code Ann. § 44-7-310.

II. THE FOURTH CIRCUIT MISINTERPRETED NAF'S STANDARDS TO SUPPORT THE DISCLOSURE OF ABORTION PATIENTS' PERSONALLY IDENTIFYING INFORMATION.

In its argument before the Fourth Circuit, South Carolina cited the 1988 NAF publication *Standards for Abortion Care* ("*NAF Standards*") as support for its assertion that South Carolina needs to access personally identifying information about abortion patients to "monitor abortions and assure compliance with the health-care standards in Regulation 61-12 aimed at preserving maternal health." *Greenville Women's Clinic*, 317 F.3d at 367. The Fourth Circuit quoted the State's citation of the NAF *Standards* at length: "[South Carolina] notes that even the National Abortion Federation . . . states that the 'maintenance of complete and accurate records is essential for quality patient care and meaningful review of services.'" *Id.* at 367-68. The Court then stated that "[t]he Federation's 'Standards of Abortion Care' explains that the 'reporting of abortion procedures and complications to appropriate private and legally sanctioned public agencies generally improve[s] family planning services and public health information.'" *Id.* at 368 (alteration in original).

The Fourth Circuit misrepresented NAF's Standards by citing them in the context of the State's claim that it needed to access abortion patients' *personally identifying* information. NAF's Standard's do not support this position. Though NAF encourages clinics to report *aggregated, statistical* information, NAF has always stressed the importance of maintaining the confidentiality of patient's *personally identifying* information. Thus, the very statement on record keeping and reporting from the NAF Standards cited by the Fourth Circuit

is immediately followed by the qualification that: "Nevertheless, within such reports, *confidentiality of individual patient identity is essential and should be safeguarded.*" *NAF Standards* 18 (emphasis added).

Since 1978, NAF has published and updated exhaustive standards, formulated by special committees of practitioners and experts, on the medical, nursing, counseling, administrative, and ethical aspects of abortion services.[7] These standards were designed to promote the health, safety, and psychological well being of abortion clinic patients. Accordingly, the standards urge maintenance of complete and accurate patient records. NAF has also advocated the compilation of statistics regarding the safety of abortion by both private and governmental entities; in particular, statistics compiled by the Centers for Disease Control ("CDC") and the Alan Guttmacher Institute are invaluable in maintaining the high standards of abortion care that exist in this country.

NAF has never suggested, however, that record keeping or the reporting of statistical information should occur at the expense of women's confidentiality. In a section entitled "Confidentiality," the same NAF Standards cited by the Fourth Circuit state: "Every woman has the right to expect her privacy will be respected and confidentiality of her records protected. . . . In addition, *if a member of the facility receives a subpoena for a woman's record, action must be taken to prohibit the release of the records without the woman's consent.*" *NAF Standards* 15-16. The NAF Standards further advise: "*The patient's record must not be re-*

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[7] In the early 1990's, NAF undertook a major revision of its standards and, relying on an evidence-based approach to clinical decision-making, replaced the standards with guidelines for quality abortion care, set forth in the publication, *Clinical Policy Guidelines*. National Abortion Federation, *Clinical Policy Guidelines* (1996), *available at* www.guidelines.gov ("*Clinical Policy Guidelines*"). These guidelines, which are reviewed and updated annually, set the standard for quality abortion care in North America.

leased without the consent (preferably in writing) of the patient." *Id.* at 15; *see also Clinical Policy Guidelines* ("all reasonable precautions must be taken to ensure the patient's confidentiality").

No entity—private or governmental—*needs* to collect personally identifying information in order to compile statistical information about abortion for public health purposes. The CDC, for instance, publishes instructions on the collection of abortion statistics. *See* CDC, *Handbook on the Reporting of Induced Termination of Pregnancy* (1997), *available at* http://www.cdc.gov/nhcs/data/misc/hb_itop.pdf. The instructions explain that: "The Report . . . is designed to collect information for statistical and research purposes only. These reports are not maintained permanently in the official files of the State health department. The data that are gathered from these reports are presented in aggregate statistics, not individually, so that specific individuals may not be identified." *Id.* at 3.

Similarly, NAF does not believe that the DHEC inspectors *need* to copy and retain abortion patients' personally identifiable information in their review of abortion providers' record keeping. As the district court noted, the "constitutional problem [in the Regulation] can be cured by . . . redacting the documents to remove such information." *Greenville Women's Clinic*, 317 F.3d at 367 (quoting *Greenville Women's Clinic v. Bryant*, No. 6:96-1898, slip op. (D.S.C. Aug. 31, 2001)).

III. THE PUBLIC DISCLOSURE OF ABORTION PATIENTS' PERSONALLY IDENTIFYING INFORMATION WILL SERIOUSLY COMPROMISE WOMEN'S ACCESS TO REPRODUCTIVE HEALTH CARE AND THE QUALITY OF THAT CARE.

Because information collected by DHEC inspectors under the Regulation could—and, indeed, has been—publicly disclosed, the Regulation will force women in South Carolina to weigh a decision to have a safe and legal abortion against

the threat of public exposure of their private health information. It is inconceivable that this threat of public disclosure would not interfere with a woman's decision to terminate a pregnancy. As this Court has made clear, "[a] woman and her physician will necessarily be more reluctant to choose an abortion if there exists a possibility that her decision and her identity will become known publicly." *Thornburgh v. American Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 766 (1986), *overruled in part on other grounds*, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). "The decision to terminate a pregnancy," this Court explained, "is an intensely private one that must be protected in a way that assures anonymity." *Id.*

In addition to the burden imposed on women's right to choose an abortion by the Fourth Circuit's decision, the threat of public disclosure of a woman's personally identifying information could have a host of damaging consequences for her health. For instance, a woman might choose not to have a medically recommended abortion if she knew that her decision could become a matter of public record, thus potentially risking not only her health but also her life. *See, e.g.*, Maureen Paul, et al., *A Clinician's Guide to Medical and Surgical Abortion* 58 (1999) ("Some cardiac lesions such as cardiomyopathy, primary pulmonary hypertension, Eisenmenger syndrome, and Marfan syndrome, considerably increase the risk of maternal death during pregnancy; abortion is often recommended, even if the pregnancy is wanted.").

The threat of public disclosure could also inhibit the candor essential to a meaningful doctor-patient relationship. This Court has established that the "physician, in consultation with his patient, [must be] free to determine, without regulation by the State, that, in his medical judgment, the patient's [first-trimester] pregnancy should be terminated." *Roe v. Wade*, 410 U.S. 113, 163 (1973). "[T]he medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient." *Doe v. Bolton*, 410

U.S. 179, 192 (1973). If a woman fails to provide a complete and accurate medical record to the doctor because she fears public disclosure, the meaningful exercise of her doctor's medical judgment would inevitably be impaired.[8]

Indeed, in health care contexts other than abortion, it is well recognized that sensitive medical information should be protected. For example, Congress passed the Health Insurance Portability and Accountability Act ("HIPAA"), *see* Pub. L. No. 104-191, § 247, 110 Stat. 1936, 2018 (1996) (codified at 29 U.S.C. §§ 1181 *et seq.*), to protect the privacy of medical information maintained by health care plans and providers. One of the stated goals of HIPPAA was the protection of personally identifying medical information. *See* 142 Cong. Rec. S9501, S9505 (daily ed. Aug. 2, 1996).

IV. THE PUBLIC DISCLOSURE OF ABORTION PATIENTS' PERSONALLY IDENTIFYING INFORMATION PUTS BOTH ABORTION PROVIDERS AND PATIENTS AT INCREASED RISK OF HARASSMENT AND VIOLENCE.

The Regulation also puts South Carolina women who have chosen to terminate their pregnancies and the doctors and clinics who provide abortions at considerably greater risk of harassment and even physical violence. NAF collects and disseminates information about the harassment of and violence against abortion providers and women seeking abortions in an effort to assist them in preventing violent attacks and managing them when they do occur. Based on extensive evidence of anti-choice harassment of and violence against abortion providers and their patients, NAF is deeply con-

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[8] Instead of giving [the doctor] an accurate medical history, a woman might well hide previous abortions, past incidents of venereal disease, or other data about her sexual activity that might be embarrassing but extremely relevant to a doctor's treatment and advice. This is a clear constraint on the development of a candid doctor-patient relationship. *See Margaret S. v. Edwards*, 488 F. Supp. 181, 214 (E.D. La. 1980).

cerned that the Regulation could cause a serious increase in violence against clinics and their patients in South Carolina.

Both women who seek abortions and physicians who provide abortions have been targets of a rising tide of anti-choice violence and harassment. Since 1977, NAF has catalogued more than 4,000 acts of violence against abortion providers and recorded more than 76,000 incidents of harassment, bomb threats, and picketing. National Abortion Federation, *NAF Violence and Disruption Statistics: Incidents of Violence and Disruption Against Abortion Providers in the U.S. and Canada* (Dec. 31, 2002), *available at* www.prochoice.org/Violence/Statistics/stats.pdf. Recently, anti-choice extremists have shifted their focus toward the harassment and intimidation of individual women visiting reproductive health care clinics. National Abortion Federation, *Analysis of Trends of Violence and Disruption Against Reproductive Health Care Clinics For 2002*, *available at* www.prochoice.org/Violence/Trends/2002.htm (last updated Feb. 6, 2003). There were 10,241 reported incidents of picketing last year, an increase from 9,969 in 2001. *Id.*

The Regulation will permit abortion opponents to identify more easily those obtaining or providing abortion services. In fact, the Regulation has already been used by anti-abortion activists to single out a patient of a South Carolina abortion clinic: as Judge King explained in his dissent, "the evidence show[ed] that abortion protesters distributed a flyer containing a photocopy of a medical record obtained from DHEC concerning a fifteen-year-old girl's pregnancy termination." *Greenville Women's Clinic*, 317 F.3d at 376 (King, J., dissenting).

Unfortunately, there is an audience, and a market, for information that personally identifies abortion patients: anti-choice activists increasingly use this information to target individual abortion patients. The Christian Gallery News Service, an organization created by Neal Horsley, founder of the Nuremberg Files web site, encourages the publication of

personally identifying information, including photographs, to deter women from having abortions. *See* www.abortioncams .com. Horsley's website features pictures of numerous women patients; he has said that "homicidal mothers must be held up for the world to see"; and he has voiced his support for the use of violence to stop abortions. *Fox Hannity & Colmes*: *Does the First Amendment Protect a Website That Posts the Names of Abortion Doctors?* (Fox News Network television broadcast, Apr. 5, 2001). And in a case in Illinois, after a patient was transferred to a local hospital because a complication occurred during an abortion, antiabortion activists acquired her medical records from a source at the hospital and posted them on the Internet along with a grainy photograph. The patient testified to the humiliation and fear she experienced as a result. *See* Jo Mannies, *Activist Admits Role in Acquiring Medical Records of Abortion Patient*, St. Louis Post-Dispatch, Aug. 23, 2001, at A1.

Indeed, the recognized harassment of abortion providers and women who seek abortions in part led Congress to pass the Driver Privacy Protection Act ("DPPA"). The legislative history of the Act documented the serious nationwide problem of women being stalked, assaulted, and at times murdered by individuals who obtained the women's home addresses from state departments of motor vehicles. *See, e.g.*, *Protecting Driver's Privacy: Hearing Before the House Subcomm. on Civil and Constitutional Rights of the House Judiciary Comm.* (1994) (statement of David Beatty, Director of Public Affairs, National Victims Center), *available at* 1994 WL 14168013; *see also* 139 Cong. Rec. S15745, S15761-65 (daily ed. Nov. 16, 1993). Senator Robb described the case of a Virginia woman who "was shocked to discover black balloons and antiabortion literature on her doorstep days after she had visited a health clinic that performs abortions. Apparently, someone used her license plate number to track down personal information which was used to stalk her." 139 Cong. Rec. at S15765. The DPPA now prohibits state departments of motor vehicles, and their employees, from

disclosing personal information about individuals without their consent. Pub. L. No. 103-322, 108 Stat. 1796, 2099-2102 (1994) (codified at 18 U.S.C. §§ 2721-2725).[9]

The disclosure of personal information, such as addresses, could also put women at increased risk of domestic violence. In 1994, Congress found that domestic violence is the leading cause of injuries to women between the ages of 15 and 44. Violent Crime Control and Law Enforcement Act of 1994, H.R. Conf. Rep. No. 103-711, at 391 (1994). Nearly 30 percent of all murders of women are committed by husbands or boyfriends. Congressional Research Service Report for Congress, *Violence Against Women: An Overview* 5 (1994). As this Court stated in *Planned Parenthood v. Casey*, 505 U.S. 833, 893 (1992), "there are millions of women in this country who are the victims of regular physical abuse at the hands of their husbands. Should these women become pregnant, they may have very good reasons for not wishing to inform their husbands of their decision to obtain an abortion." *See also* Janlori Goldman et al., *Health Privacy Principles for Protecting Victims of Domestic Violence* (2000), *available at* http://www.ihealthbeat.org.

Finally, the violence directed at abortion providers directly threatens the ability of women to obtain safe abortions. As one expert has noted: "harassment and intimidation may dissuade skilled clinicians from entering this field, or convince them to quit." *See* David A. Grimes, *Clinicians Who Provide Abortions*, 80 Obstetrics and Gynecology 719, 721 (1992). Doctors, nurses, and administrators have been

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[9] *See also Operation Rescue v. Women's Health Center*, 626 So. 2d 664, 668 (Fla. 1993), *rev'd in part, Madsen v. Women's Health Center, Inc.*, 512 U.S. 753 (1994) (discussing the recording of license plate numbers at an abortion clinic by anti-choice activists); *Morning Edition: Florida Lawsuit Charging Compuserve and Anti-Abortion Protester Violated Rights of Abortion-Seekers and Workers by Tracking Them Down with Their License Plate Numbers* (National Public Radio broadcast Feb. 16, 1999) (same).

stalked, assaulted, and sometimes murdered; faced with such harassment and violence, many choose to resign. *See* Kimberly A. Lonsway et al., *2002 National Clinic Violence Survey Report* (rel. Mar. 2003), *available at* http://www.feminist.org/research/cvsurveys/clinic_survey2002.pdf.

CONCLUSION

For the reasons set forth above, this Court should grant the petition for writ of certiorari and reverse the decision of the Fourth Circuit.

Respectfully submitted,

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IN THE

Supreme Court of the United States

GREENVILLE WOMEN'S CLINIC; WILLIAM LYNN, M.D., ON BEHALF OF THEMSELVES AND THEIR PATIENTS SEEKING ABORTIONS,

Petitioners,

v.

COMMISSIONER, SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL; GOVERNOR OF SOUTH CAROLINA; HENRY MCMASTER, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE STATE OF SOUTH CAROLINA,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

REPLY TO BRIEF IN OPPOSITION

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Respondents' Brief in Opposition ("Op. Cert.") underscores the importance of the issues presented by this case, interprets the relevant legal standards in ways that create additional circuit splits, and thus provides this Court with additional reasons to grant *certiorari*.

I. Respondents' Assertion That Informational Privacy Rights Can No Longer be Asserted in Facial Challenges to Abortion Regulations Provides an Additional Basis for Granting *Certiorari*.

As Petitioners have explained, the decision below contributes to a significant split in the circuits by upholding section 102(F)(2) ("disclosure provision") of S.C. CODE ANN. REGS. 61-12 (2002) ("R. 61-12" or "the Regulation"), which permits the South Carolina Department of Health and Environmental Control ("DHEC") to review and copy abortion patients' complete medical records without protecting those records from authorized disclosure.[1] Pet. for Writ of Cert. ("Pet.") at 8-20. The Petition demonstrates that the circuit courts are divided both on whether a constitutional right to informational privacy exists, and on how claims under that right should be analyzed.

Respondents admit that under the Regulation unredacted medical records of abortion patients are subject to public disclosure in administrative proceedings, Op. Cert. at 10 n.8, and they make no attempt to refute the existence of a circuit split regarding the existence and scope of a right to informational privacy. Thus, Respondents have simply failed to address the issues presented by this Petition.

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[1] Respondents attempt to distract from the issues presented by characterizing the disclosure provision as a "recordkeeping and reporting requirement." *See, e.g.*, Op. Cert. at 4. Allowing DHEC to copy and remove patient medical records and expose them to public disclosure is not a recordkeeping or reporting requirement, and Petitioners challenge no such requirements.

Instead, Respondents claim that any questions regarding the existence or scope of a right to informational privacy are irrelevant here because this Court's decision in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), "displaced" that right for abortion patients, at least in the context of facial challenges to abortion restrictions. Thus, according to Respondents, if a law being challenged as a violation of the right to informational privacy regulates abortion, then only the "undue burden" test of *Casey* applies, and the constitutional analysis undertaken in *Whalen v. Roe*, 429 U.S. 589 (1977), has no application.[2]

This argument lacks support from any court, including the Fourth Circuit, and, if accepted, would give abortion patients' medical records less constitutional protection than any other private materials, which would be governed by *Whalen*. Under *Whalen*'s informational privacy analysis, a disclosure requirement will be struck down unless the disclosure is adequately justified and the state provides sufficient confidentiality safeguards for the disclosed material. 429 U.S. at 594-98. By contrast, a disclosure requirement will only be struck down under the undue burden standard if it actually prevents women from "mak[ing] the ultimate decision" to undergo an abortion. *Casey*, 505 U.S. at 877, 879. Affording abortion patients' medical records less privacy protection than other confidential materials is inconsistent with this Court's decisions, which recognize the importance of confidentiality

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[2] In its scant response to Petitioners' claim under *Whalen*, Respondents offer no justification for needing to inspect and copy patients' unredacted records, and they concede that such records may be disclosed in administration proceedings. Op. Cert. at 10 n.8. Nonetheless, Respondents assert that this explicit authorization of disclosure provides insufficient grounds for finding a lack of privacy protection. *Id.* Petitioners submit that where state law explicitly authorizes public disclosure of confidential information, a finding of inadequate privacy protections is not only justified, but inevitable.

in the physician-patient relationship generally and with respect to women's abortion decisions specifically. *See Ferguson v. City of Charleston*, 532 U.S. 67, 78 (2001); *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 766 (1986).

Moreover, if Respondents are correct that *Casey* "displaced" abortion patients' right to informational privacy, then this Court should grant *certiorari* to say so. As Respondents' concede, *Casey* made no such holding and therefore litigants and the lower federal courts are unable to rely on that proposition. Op. Cert. at 7 n.6 ("it is not even clear that the State could have pressed the displacement argument with much vigor in the courts below because, at least at a general level, *Whalen* would appear to govern the informational privacy claims in this case"). If *Casey* indeed prevents women from being able to challenge abortion restrictions on their face on any basis other than an undue burden challenge, then that is unquestionably an important constitutional question that should be settled by this Court. *See* SUP. CT. R. 10(c).

II. This Court Should Grant *Certiorari* to Decide Whether States May Require Private Individuals to Form Religious Affiliations.

As Petitioners have demonstrated, and Defendants concede, the Regulation requires physicians to form affiliations with clergy in order to be licensed as abortion providers. *See* Op. Cert. at 18 (R. 61-12 "requires abortion providers to have relationships with" the various "specialists" listed in § 307, which include clergy).[3] Thus, the question for this Court is whether such forced affiliations are facially unconstitutional. They clearly are under this Court's

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[3] Defendants fail to address the patently unconstitutional requirement that the consulting clergy include one Protestant. Pet. at 5, 25.

decisions in *Lee v. Weisman*, 505 U.S. 577, 587 (1992), and *Santa Fe Indep. Sch. Dist. v. Doe*, 530 U.S. 290, 310-12 (2000), which prohibit the states from forcing individuals to participate in and support religion. *See Lee*, 505 U.S. at 604 (Blackmun, J., concurring, with Stevens, J., O'Connor, J.) (emphasizing that "[a]lthough our precedents make clear that proof of government coercion is not necessary to prove an Establishment Clause violation, it is sufficient. Government pressure to participate in a religious activity is an obvious indication that the government is endorsing or promoting religion").[4] As Petitioners explained more fully in their petition, requiring physicians to establish relationships with clergy and make professional referrals to clergy forces them to participate actively in and support religion. Pet. at 24-25.

Faced with this precedent, Respondents claim that under *Bowen v. Kendrick*, 487 U.S. 589 (1988), forced affiliation with religion is constitutionally permissible so long as it is accompanied by forced affiliation with non-religious persons or organizations. Op. Cert. at 16-18. *Bowen* is inapposite, however, because it did not involve state regulation of private conduct. The law challenged there required that certain government funded programs involve both religious and non-religious organizations in their delivery of services.[5] In upholding that element of the challenged funding scheme, this Court held it "reflect[ed] the statute's successful

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[4] The State's assertion that the "no set of circumstances" test of *United States v. Salerno*, 481 U.S. 739, 745 (1987), applies to Establishment Clause claims is refuted by *Bowen v. Kendrick*, 487 U.S. 589 (1988), the case on which Defendants so heavily rely. In *Bowen*, this Court applied the test of *Lemon v. Kurtzman*, 403 U.S. 602 (1971), without mention of *Salerno*. *Bowen*, 487 U.S. at 602.

[5] Moreover, it is not apparent that the statute challenged in *Bowen* actually required inclusion of religious organizations by grantees, or simply permitted inclusion of religious groups along with a variety of other groups. *Bowen*, 487 U.S. at 605-7.

maintenance of 'a course of neutrality among religions, and between religion and non-religion.'" *Bowen*, 487 U.S. at 607 (citation omitted). Thus, government programs may involve religious organizations so long as the government is neutral among religions and as between religion and non-religion.

Bowen has no application to the regulation of private conduct, where this Court has never permitted a government to require individuals to support or participate in religion or to maintain a position of neutrality among religions or between religion and non-religion. There is certainly a significant difference between coercing private individuals to affiliate with religious personnel and requiring neutrality as to religion in government-funded programs. *See Doe v. Maher*, 432 U.S. 464, 475-476 (1977) (holding that there is a "basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy"). The Regulation does the former by imposing criminal penalties on physicians who fail to form the religious affiliations required by the clergy provision. *See* S.C. CODE ANN. § 44-7-340 (2002) (violation of the Regulation is a misdemeanor). *Bowen* is simply not instructive in this context.

Should this Court agree with Respondents that *Bowen* controls the outcome of Petitioners' Establishment Clause claim, then the Court should grant *certiorari* to settle this important issue. *See* SUP. CT. R. 10(c). This is particularly necessary because the circuit courts have not interpreted *Bowen* in the manner Respondents suggest, and have instead continued to follow the rule that states may not require individuals to participate in and support religion. *See, e.g.*, *Kerr v. Farrey*, 95 F.3d 472, 479-80 (7th Cir. 1996) (striking down prison policy coercing inmate to participate in religion); *Warner v. Orange County Dep't of Prob.*, 115 F.3d 1068, 1075-77 (2d Cir. 1996) (same).

In light of the plain unconstitutionality of the clergy

provision, Respondents now half-heartedly attempt to disown DHEC's interpretation of section 307. *See* Op. Cert. at 14 and n.10. That interpretation, which is described more fully in the Petition, Pet. at 4-5, was given at trial by George Moore, who is not just "one individual," as Respondents suggest, Op. Cert. at 14, but the principal drafter of the Regulation and the Director of Outpatient and Home Care in DHEC's Division of Licensing. Mr. Moore testified at trial in his official capacity, and DHEC has never disputed Mr. Moore's interpretation nor denied that his testimony reflects the agency's position. Instead, Respondents have repeatedly defended the constitutionality of that interpretation. *See, e.g.*, Defs.' Mem. in Opp. to Pls.' Request for Relief at 21-26 (filed in district court Aug. 6, 2001); Brief of Appellees/Cross-Appellants at 33-39 (filed in court of appeals Dec. 27, 2001). Notably, Respondents have neither adopted nor attempted to defend the Fourth Circuit's interpretation of the clergy provision, which is plainly incorrect, and have instead conceded that the Regulation requires physicians to establish relationships with the various specialists listed in section 307. *See* Op. Cert. at 18. For the reasons explained above and in the Petition, such a requirement is facially unconstitutional.

III. The Regulation Allows Area Hospitals to Prevent Abortion Facility Licensing on the Basis of Opposition to Abortion.

As the Petition explains, the Regulation violates abortion providers' right to due process by granting area hospitals standardless authority to prevent abortion facility licensing by denying admitting privileges to abortion providers. Pet. at 26-28. Respondents attempt to defend this grant of authority by claiming that it is adequately constrained by due process requirements. Respondents are incorrect.

Neither public nor private hospitals are subject to any due

process constraints with respect to their decision to become certified as facilities suitable for the provision of abortions. Yet the Regulation requires an abortion provider to hold admitting privileges at a hospital that has obtained that certification, or to have a documented transfer arrangement with such a hospital and a written consulting agreement with a physician who has admitting privileges at such a hospital. *See* Pet. at 5. Thus, abortion providers' licensing is contingent upon the hospital's act of complete discretion as to whether to become certified for abortion provision.

Moreover, in South Carolina, private hospitals can deny admitting privileges for any reason at all, *Modaber v. Culpeper Mem'l Hosp.*, 674 F.2d 1023 (4th Cir. 1982), and public hospitals can deny privileges in accordance with a hospital rule or policy opposing abortion in the facility. *See Huellmantel v. Greenville Hosp. Sys.*, 402 S.E.2d 489, 492 (S.C. Ct. App. 1991) (holding that "due process requires only that a public hospital not exclude a physician from practice therein by rules or acts which are unreasonable, arbitrary, capricious or discriminatory"). Federal constitutional law permits private and public hospitals to prohibit the performance of abortions in their facilities, *see Webster v. Reprod. Health Servs.*, 492 U.S. 490, 509-10 (1989), and South Carolina law explicitly protects private hospitals that refuse to permit the performance of abortions in their facilities. S.C. CODE ANN. § 44-41-40 (2002). Any hospital in South Carolina can follow the legislature's lead by adopting a policy disfavoring the performance of abortions in the facility. Such a hospital could then prevent abortion providers from obtaining abortion facility licenses by denying admitting privileges in accordance with that policy.

Thus, the Regulation grants hospitals authority to prevent abortion facility licensing on grounds not available to the State. Such a delegation is impermissible. *See Planned Parenthood v. Danforth*, 428 U.S. 52, 69 (1976) (holding that

the state may not delegate to a private party authority that the state does not have); *Causeway Med. Suite v. Ieyoub*, 109 F.3d 1096, 1109-10 (5th Cir. 1997) (striking down a delegation of standardless veto power over minors' abortions to judges, because it allowed judges to deny abortions in circumstances in which the state must approve them); *Hornsby v. Allen*, 326 F.2d 605, 609-10 (5th Cir. 1964) (holding that licensing decisions must be based on established standards so that potential licensees are not subject to uncontrolled discretion of licensing authorities).[6]

Finally, Respondents rely on the Eighth Circuit's decision in *Women's Health Ctr. of West County, Inc. v. Webster*, 871 F.2d 1377 (8th Cir. 1989), for the proposition that admitting privilege requirements must be constitutional because this Court has upheld requirements that abortion providers be licensed physicians. That parallel, however, is improperly drawn because medical boards are subject to strict standards governing their exercise of authority. Unlike the hospitals here, medical boards may only grant or deny a license to practice medicine on the basis of individual merit. *See, e.g., Schware v. Bd. of Bar Exam'rs*, 353 U.S. 232, 238-39 (1957). Moreover, to the extent the *Webster* upholds a grant of governmental authority that may be exercised on the basis of whim or opposition to abortion, it conflicts with *Danforth*, *Causeway* and *Hornsby*, and this Court should grant *certiorari* to resolve that conflict. *See* SUP. CT. R. 10(a).[7]

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[6] Respondents also argue that this Court should not address Petitioners' due process claim until the Regulation's delegation of licensing authority imposes an undue burden on women. Respondents essentially claim that *Casey* eclipsed all other constitutional rights in challenges to abortion regulations. But *Casey* never so held, and abortion providers have a right, like anyone else, to due process of law.

[7] The assertion that Petitioners have experienced no difficulty in obtaining admitting privileges is patently false. Dr. Lynn was unable to

IV. The Regulation Grants DHEC Inspectors Unbridled Discretion to Define New Requirements for Abortion Facilities.

As the Petition demonstrates, section 103(C) of the Regulation conflicts with decisions of this Court and the circuit courts by allowing DHEC inspectors to define new requirements of the Regulation on a case by case basis and to cite and fine facilities for violations of those new requirements. Pet. at 28-30. This provision violates "the more important aspect of vagueness doctrine... -- the requirement that a legislature establish minimal guidelines to govern law enforcement." *Kolender v. Lawson*, 461 U.S. 352, 358 (1983) (internal quotation omitted). Because section 103(C), like the law challenged in *Kolender*, "contains no standard for determining" what DHEC's best practices are, it "vests virtually complete discretion in the hands of" state authorities to determine whether individuals are in compliance with the law. *See Kolender*, 461 U.S. at 358. Although respondents claim that the Regulation contains adequate standards for enforcement, this contention finds no support in the Regulation, which lacks any standards governing how inspectors define "best practices," and contains only a general list of factors to be considered in imposing penalties. *See* R. 61-12 § 103(E).

Respondents counter the obvious notice problem presented by section 103(c) by pointing to the fact that monetary violations cannot be imposed for a first violation of a "best practice," and after that first violation, the provider is

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obtain privileges at a local hospital in Greenville because he does not reside there, and it took him months to obtain a written agreement with a physician who had such privileges because area physicians feared harassment and violence if they associated themselves with an abortion provider. Dec. of William Lynn, M.D. ¶ 8 (filed Feb. 26, 2001).

on notice of the requirements of the law.[8] This very same argument was made and rejected in *City of Chicago v. Morales*, 527 U.S. 41, 56-60 (1999), where this Court held that the fact that an enforcement officer will announce the terms of a vague law prior to imposing sanctions does not alleviate the lack of notice problem created by such a law. *Id.* As this Court explained, "[s]uch an order cannot retroactively give adequate warning of the boundary between the permissible and the impermissible applications of the law." *Id.* at 59. Thus, Section 103(c) violates both aspects of the vagueness doctrine.

CONCLUSION

For the foregoing reasons, Petitioners respectfully request that the Court grant their petition for a writ of *certiorari*.

Respectfully submitted,

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[8] A "best practices" violation subjects the abortion provider to monetary penalties the day after it is announced. R. 61-12 § 103.